FINAL REPORT AND RECONCILIATION

PRESENTED TO: CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,
FEDERAL GRANTS DIVISION

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS FOUNDATION AND
CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
Contract Number 22-20410
SOR III

SUBMITTED JUNE 27, 2024

CAFP FOUNDATION

Investing in the future of family medicine

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CAFP
California Academy of Family Physicians

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EXECUTIVE SUMMARY

SAMHSA and DHCS support of our California Residency Program Collaborative (CRPC) and other activities funded through SOR III have made a real impact on patient lives in California and have set in motion cultural and systems changes that will lead to sustainability and improvements far beyond this grant cycle.

This multi-specialty physician residency program collaborative has exceeded our expectations. We see before our eyes a sea change in SUD care where interns and residents who knew very little about addiction care and medication for opioid use disorder (MOUD), end up as champions and trainers to their colleagues (and many times re-trainers of attending faculty) that has resulted in a new culture and standard of care in these residency programs. These residents will continue throughout their careers to affect positive change and we are humbled and proud to be a part of this process.

"As the healthcare system begins to realize and fund 'addiction as a treatable chronic condition,' CRPC and DHCS support is critical to demonstrate the moral and financial data to sustain and expand SUD services." ~ CRPC-3 Grantee

We asked our grantees to complete this statement, "Without this Collaborative and CRPC resources, we would not have been able to…" Their responses are in their final reports (see Appendix I). However, we wanted to highlight a few of them to quickly demonstrate the true value of this work:

Without this Collaborative and CRPC resources, we would not have been able to…

- Change a hospital and community culture surrounding substance use disorder and its associated conditions
- Inspire the next generation of family physicians to view substance use disorder as a chronic, treatable disease which they can address
- Initiate adolescent addiction services that provide immediate harm reduction, evidenced based SUD care and longitudinal follow up.
- Transform addiction education and care in our region
- Remove institutional barriers for primary care physicians at Kaiser Permanente San Diego to prescribe Suboxone for OUD or Chronic Pain.
- Design, deliver and sustain a culture of low threshold MAT for AUD
- Seriously affect the policies of the hospital to become MAT friendly and OUD understanding.
- Realize a large [unmet] diagnostic and treatment need for our clinic patients and bring new processes and resources to bear in helping meet and sustain their treatment needs.
- Build an energetic community of health care providers with the expertise to care for marginalized individuals while simultaneously challenging and improving the system of care.

In addition to success, we also identified ongoing barriers to progress and some of these are described in our Quality Improvement section below on page 33. One of the most onerous obstacles to progress includes Pharmacy policies, formularies, and actions thwarting access to buprenorphine. Undue and outright fear of DEA and CDPH audits exists which limits what can be done for patients in need. In the end, these attitudes and fears undoubtedly result in more overdose deaths and injuries. Another barrier was the lack of ability to use grant funds for contingency management. Not all our grantees were in the pilot counties that offered these funds. We hope the restriction can be lifted for future grants.

During this grant cycle, we were fortunate to be able to develop a framework anchored to our three overarching objectives: increase the identification of those in need of treatment, expand treatment, and

expand harm reduction services, that allowed us to demonstrate the collective ability of our collaborative to move the needle on our overarching objectives.

Some high-level data points of our progress over SOR III (14 months, April 2023-May 2024) include:

- *Increased **identification** of SUD: 8,781 screened for mental health.*
- *Expanded **treatment**: 5,253 patients referred to SUD recovery services.*
- *Expanded **harm reduction**: 6,100 xylazine test strips distributed, 13,442 units of naloxone distributed.*

This grant has contributed to California being on the leading edge of efforts to increase the number of primary care providers offering MOUD. Not only through our Residency Collaborative, but also through two important initiatives: the MOUD champions program and the Treating Addiction in Primary Care Podcast Series. Both efforts have been recognized by the National Institute on Drug Abuse (NIDA). Our data has indicated that ***333 more providers began prescribing MAT/MOUD*** through our collective efforts.

We are thankful for the team we worked with, Anita Charles, CAFP Education Program Manager, Laurie Isenberg, MILS, CHCP, CAFP Director of Education and Professional Development, Pam Kittleson, RPh, IPMA Director of Quality, and Sheila Robertson, Data Consultant. We also wish to thank Christina Flores, Stephanie Williams, Vicki Watkins and other team members at the Department of Health Care Services, who have supported our work throughout the project.

Carol Havens, MD, FAAFP
CRPC-3 Chair, Executive Advisory Panel

Jerri L. Davis, CHCP
CAFP Vice President, Education and Professional Development

Pamela Mann, MPH
CAFP Foundation Executive Director

Project Goals and Objectives

As stated in the approved Request for Applications (RFA), the overall goal of this initiative was to reduce opioid overdose-related deaths, particularly in the most vulnerable populations, while encouraging creative and innovative approaches to meeting program and community needs.

With these goals in mind, we selected three objectives for the RFA:

- **Identify those in need of treatment**
- **Initiate/engage/sustain individuals in treatment**
- **Expand harm reduction**

We encouraged applicants to use SMART goals/objectives and include an action plan and measurable outcomes, a methodology to both implement the action plan and measure the project's impact, and a timeline for spread and plan for sustainability. While continuous assessment of the project goals/objectives and participation in the quality improvement module resulted in several of the grantees revising their initial proposals, we believe the ultimate outcomes proved very successful and we are proud of all that was accomplished through this learning collaborative and overall project.

CRPC Expert Advisory Panel (EAP)

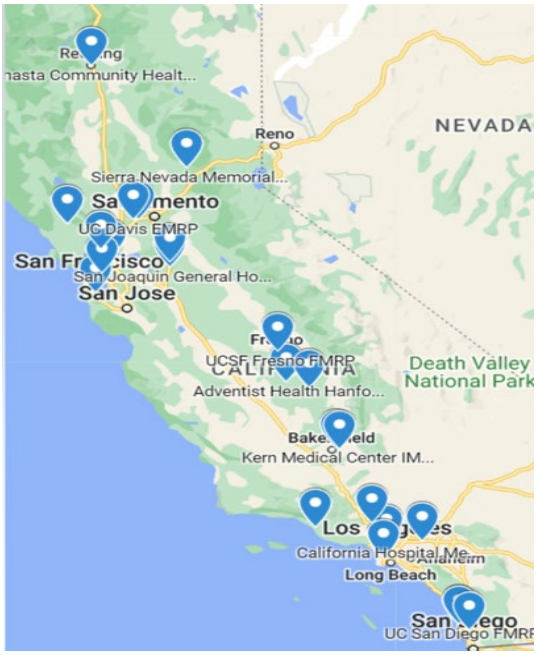
The project's Expert Advisory Panel, chaired by Carol Havens, MD, FAAFP, was identified and invited based on a series of criteria. We sought to have a broad panel, with representatives from a variety of specialties, locations, and practice settings. The panel members participated in a thorough review of the Request for Proposal; grant review, scoring and grantee selection; development of educational content; webinars and meetings. They also served as clinical advisors for staff and grantees throughout the project, attended webinars and meetings and were always willing to help when asked. We are very appreciative of their support.

"These programs have done such amazing and truly inspirational work. They are having such an impact on the lives of their patients and their colleagues and programs." ~ Carol Havens, MD, FAAFP, FASAM

"I knew I was impressed with these grantees before but after seeing them present the highlights of their accomplishments at the convocation, I am absolutely floored!" ~ Jean Marsters, MD

EAP Members	Specialty/Constituency
Carol Havens, MD, FAAFP, FASAM, EAP Chair	Family Medicine and Addiction Medicine, Chair, CAFP's Committee on Continuing Professional Development
Thomas C. Bent, MD, FAAFP	Family Medicine, CAFP Foundation Board of Trustees
Cynthia Chatterjee, MD	Psychiatry, Addiction Medicine
Condessa Curley, MD, MPH, FAAFP	Family Medicine, Public Health
Tipu V. Khan, MD, FAAFP, FASAM	Family Medicine and Addiction Medicine with emphasis in Obstetrics
Jean Marsters, MD	Psychiatry and Addiction Medicine
Heyman Oo, MD	Pediatrics
David Pating, MD	Psychiatry and Addiction Medicine
Michael Potter, MD, FAAFP	Family Medicine, Practice based research
Elisa Pujals, MD	Family Medicine, MAT/MOUD Champion
Siddarth Puri, MD	Psychiatry, Addiction Medicine (former grantee)
Jesse Ristau, MD	Internal Medicine, Addiction Medicine

CRPC Grantees



• Adventist Health Hanford Family Medicine Residency Program • Adventist Health Tulare Family Medicine Residency Program • California Hospital Medical Center Family Medicine Residency Program • Contra Costa Regional Medical Center Family Medicine Residency Program • Harbor-UCLA Pediatric Medicine - Family Medicine Residency Program • Harbor-UCLA Internal Medicine - Family Medicine Residency Programs • Highland Hospital / Alameda Health System Emergency Medicine Residency Program • Kaiser Permanente Santa Rosa Family Medicine Residency Program • Kaiser Permanente Vallejo Family Medicine Residency Program (Fourth Second: One Love Vallejo Mobile Health) • Kaiser Permanente San Diego Family Medicine Residency Program • Kern Medical Center Internal Medicine Residency Program • Olive View UCLA Medical Center Emergency Medicine Residency Program • Pomona Valley Hospital Medical Center Family Medicine Residency Program • Rio Bravo Family Medicine Residency Program • San Joaquin General Hospital Family Medicine Residency Program • San Mateo County Psychiatry Residency Training Program • Shasta Community Health Center Family Medicine Residency Program • Sierra Nevada Memorial Hospital Family Medicine Residency Program • St. Joseph's Medical Center Stockton Emergency Medicine Residency Program • UC Davis Emergency Medicine Residency Program • UC Davis Family Medicine Residency Program • UC San Diego Family Medicine Residency Program • UC San Diego Internal Medicine Residency Program • UC San Francisco Fresno Family Medicine Residency Program • Ventura County Medical Center Family Medicine Residency Program

We received a total of 36 qualified applications. Ultimately, the 25 programs recommended by the EAP using the approved DHCS scoring rubric, and approved by DHCS, were approved. They represented both community-based and academic medical center-based residency programs. Their specialty and geographic breakdown follows:

Medical Specialty
16 - Family Medicine (FM) proposals
1 - combined Family Medicine-Internal Medicine (IM) proposal
1 - combined Family Medicine -Pediatrics proposal
4 - Emergency Medicine proposals
2 - Internal Medicine proposal
1 - Psychiatry proposal

Geographic Range (counties)
7 - Central Valley: Fresno, Kern (2), Kings, San Joaquin (2), Tulare
9 - Northern CA: Alameda, Contra Costa, Nevada, Shasta, Sacramento (2), San Mateo, Solano, Sonoma
9 - Southern CA: Los Angeles (5), Ventura, San Diego (3)

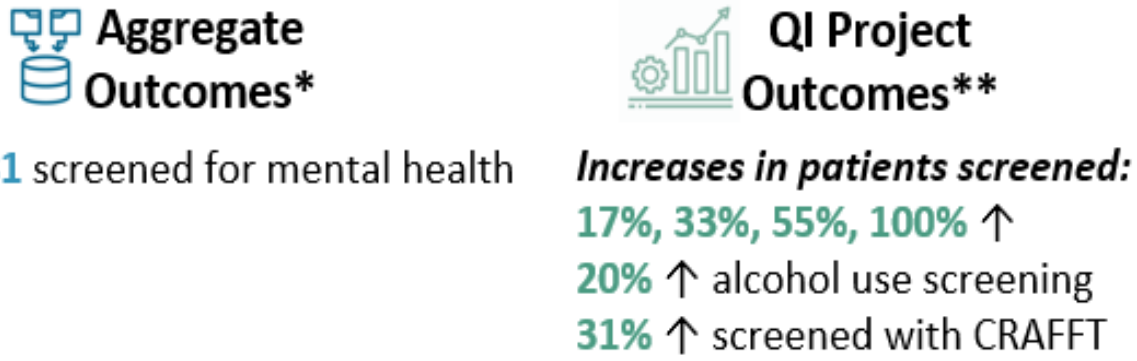
AGGREGATE OUTCOMES/HIGHLIGHTS

A data framework that highlights change
We developed a framework anchored to our three overarching objectives: increase the identification of those in need of treatment, expand treatment, and expand harm reduction services. Aggregate outcomes collected from all grantees (such as the DHCS/UCLA quarterly report data), as well as QI Project and other outcomes data that were more individualized based on grantee projects, were then grouped under respective objectives. This helps demonstrate the collective ability of our collaborative to move the needle on our overarching objectives. Outcomes highlights for each objective are shown below.

Objective 1: Identifying those in need of treatment

Example grantee activities:

- Initiated SUD screening and providing MOUD at multiple clinic sites through increasing provider confidence and establishing screening protocols and standard workflows.



**Per quarterly reports covering 14 months, approx. 4-1-23 through 5-30-24*
***Per QI Online Module, improvement over baseline. Numbers represent the percent of key aim achievement at project conclusion minus the percent of achievement at baseline. Some started at 0%, others started higher. Some reached full potential during the relatively short data collection timeframe (8-10 months), and others are trending positive and expected to reach/sustain potential as the projects' momentum continues into the future.*

Objective 2: Initiate/Engage/Sustain Individuals in Treatment

Example grantee activities:

- Created resident rotations that service incarcerated patients
- Train the trainer/faculty development fellowship (shadowing & education)
    - Connected multispecialty providers in health system; hands-on training and education
- Provided education and training to increase nursing staff knowledge about MOUD and their participation in patient screening
- Initiated teen advisory panels to hear from local teen community about issues that they see within their life and school around SUD
- Developed and shared order sets for micro and macro dosing
- Launched Addiction Medicine Elective for residents
- Increased services to unhoused patients through "backpack medicine program" and expanded number of street medicine teams
- Provided residents (and now nurses who previously were opposed to involvement) with training on long-acting injectables (LAIs)
- Changed hospital policies that are barriers to care or used to target patients with SUD (i.e. ending MAT formulary restrictions)
- Addressed system barriers by providing data to leadership to show benefits to providing prompt services to SUD patients

"We had the pleasure of seeing a gentleman in his mid 60's who suffers from schizoaffective disorder, methamphetamine use disorder and has been living with HIV for >20 yrs. During an outpatient visit for HIV my resident noticed amphetamine use disorder in his chart and that he had been referred to an addiction specialist. Inquiry revealed his intake with the addiction specialist had been rescheduled multiple times and to his knowledge he had never been offered medication for his methamphetamine struggles. After a conversation about his use history and discussion of options, the patient desired to trial Naltrexone. Upon 1 week follow up he had moved from twice daily use routinely to zero use in the first week. Naltrexone gave him the power to quit immediately and now; >4 months out, he has yet to relapse. For me, this reinforces the potential that family medicine doctors have to intervene in the lives of their patients and their communities. ***Educational funding that CRPC provides drives this change, and our patients are forever blessed."***

Aggregate Outcomes*

Attended Training:
3,779 MAT
1,935 Other SUD Tx

***Began* prescribing MAT: 333**

Patients Referred:
2,939 to SUD treatment services
5,253 to SUD recovery services
1,494 to housing services

QI Project Outcomes**

41%, 100% ↑ trained on MAT
67%, 84% ↑ patients received MAT
38% ↑ inmates receive OUD care
15% ↑ ED SUD pts f/u in 30 days
1.44 ↑ MAUD rx/month in PC

Objective 3: Expand Harm Reduction Services

Example grantee activities:

- Deployed cutting edge sophisticated harm reduction vending machines reaching some of our most vulnerable patients with SUD
- Increased distribution of Narcan in many ways
- The "View from the Street" webinar led to many planned changes in practice in this area

Aggregate Outcomes*

Attended Training:
1,707 overdose & naloxone
1,402 harm reduction

Distributions:
13,442 naloxone
6,100+ xylazine test strips
1,750+ fentanyl test strips
933 safer consumption kits

The Highland Emergency Medicine (EM) resident team collaborated with Alameda County Healthcare for the Homeless (ACHCH), Cardea Health, and Bay Area Community Services (BACS) to set up the first iteration of a mobile medication-assisted treatment (MAT) clinic at the Henry Robinson center, a BACS transitional housing center for 137 Oakland residents.

TECHNICAL ASSISTANCE, EDUCATION & SUPPORT

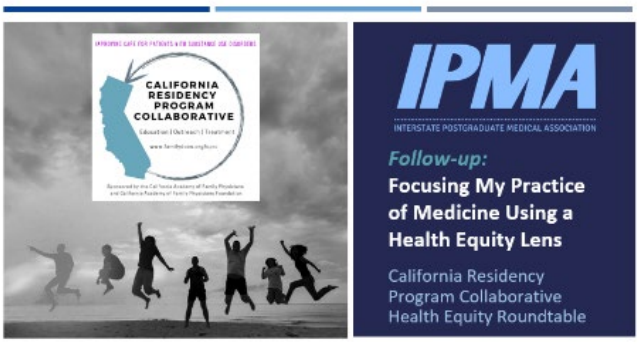
Members of the EAP, the CAFP, and Interstate Postgraduate Medical Association (IPMA) designed, developed, and implemented several activities and educational offerings based on the grant proposal submitted to DHCS and, of course, on grantees' needs. The activities included webinars, regional workshops, a performance improvement project, live and enduring education materials, links to DHCS information and a robust online resource library. We accredited many of the educational sessions, offering learners a total of 12.50 CME/CE credits through this collaborative, excluding the additional credit offered through the Quality Improvement module described below. Our grantees also participated in regular check-in calls, data reporting and email updates with the CAFP and IPMA teams.

Education – Content Development

Designing and delivering educational content on important topics is an important part of this collaborative project. We engaged with addiction medicine experts, state and local community leaders, and even law enforcement to produce timely relevant, and impactful, education for our grantees.

Health Equity Education

A strong focus on health equity was integrated in our collaborative for this 2023-2024 cycle. In line with this focus, IPMA developed educational sessions aimed at improving care for patients with substance use disorders (SUD) to address this focus. These sessions were designed to foster a collaborative approach to addressing health equity challenges in SUD treatment, promoting continuous improvement and innovation.

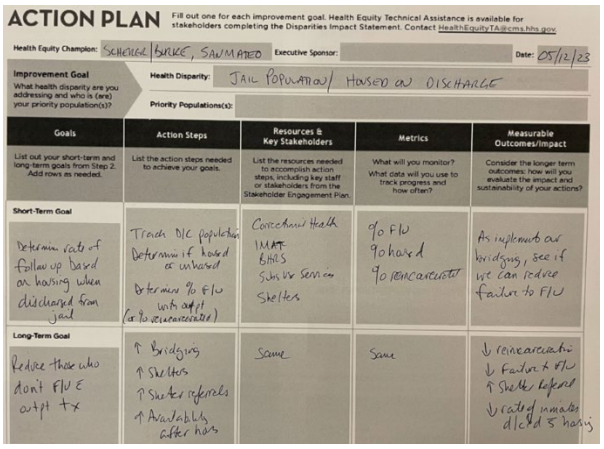


Learning Objectives:

- Recognize the impact of Social Determinants of Health (SDOH) on patient outcomes.
- Apply the CMS Disparities Impact Statement Framework to develop SMART goals for advancing health equity in SUD programs.

The educational components featured two key items:

1. ***In-person Sessions (May 2023)****:*
   - **Locations and Dates**: Held in Sacramento and Los Angeles on May 12-13, 2023.
   - **Faculty**: Dr. Alvia Siddiqi and Dr. Debra Levinthal led the sessions, focusing on integrating health equity goals into SUD programs.
   - **Activities**: These half-day sessions introduced Health Equity (HE), showcased a case study from a large health system, and introduced the CMS Disparities Impact Statement Framework & Action Plan.
   - **Workshops**: 21 Participants engaged in interactive small group sessions where they used the CMS framework to develop short-term health equity goals tailored to their specific projects.
   - **Outcome**: The sessions concluded with group presentations of action plans, followed by discussions and feedback, enhancing participants' skills in addressing health disparities.
   - Participants described their learning experience with words such as "Inspired," "Curious," and "Reinvigorated," highlighting the positive impact of the sessions.
   -
2. ***Wrap-up Webinar (April 2024)****:*
   - **Focus**: This session reviewed the results and learnings from the year's programs, highlighting the successful integration of health equity into SUD treatment.
   - **Discussion**: 26 Participants discussed the successes and challenges of the past year, including cultural and logistical barriers, and shared strategies developed to enhance the integration of health equity into their projects.
   - **Feedback**: The collaborative nature of the webinar facilitated a rich exchange of ideas and experiences, aimed at fostering ongoing improvement and innovation.
   - **Impact on Projects**: 5 of 6 responding participants strongly agreed the sessions made them more effective in integrating Health Equity goals into their SUD programs. The aggregate outcomes data through May 2024 reported 4,139 individuals from underserved and/or diverse communities were reached through community outreach events and activities associated with the 2023-2024 CRPC3 projects.



ACTION PLAN

Fill out one for each improvement goal. Health Equity Technical Assistance is available for stakeholders completing the Disparities Impact Statement. Contact HealthEquityTA@cms.hhs.gov

Health Equity Champion: SCHERER/BURKE, SAMMATEO Executive Sponsor: Date: 05/12/23

Improvement Goal — What health disparity are you addressing and who is (are) your priority population(s)?

Health Disparity: JAIL POPULATION/ HOUSED ON DISCHARGE

Priority Population(s):

Goals	Action Steps	Resources & Key Stakeholders	Metrics	Measurable Outcomes/Impact
List out your short-term and long-term goals from Step 2. Add rows as needed.	List the action steps needed to achieve your goals.	List the resources needed to accomplish action steps, including key staff or stakeholders from the Stakeholder Engagement Plan.	What will you monitor? What data will you use to track progress and how often?	Consider the longer term outcomes: how will you evaluate the impact and sustainability of your actions?
Short-Term Goal: Determin rate of follow up based on housing when discharged from jail	Track DIC population Determin if housed or unhoused Determin % F/U with outpt (or to reincarceration)	Correctional Health IMAT BHRS Substance Services Shelters	% F/U % housed % reincarceration	As implement our bridging, see if we can reduce failure to F/U
Long-Term Goal: Reduce those who don't F/U E outpt tx	↑ Bridging ↑ Shelters ↑ Shelter referrals ↑ Availability after hours	Same	Same	↓ reincarceration ↓ Failure to F/U ↑ Shelter referral ↓ rate of inmates dicharged & housing

Summary

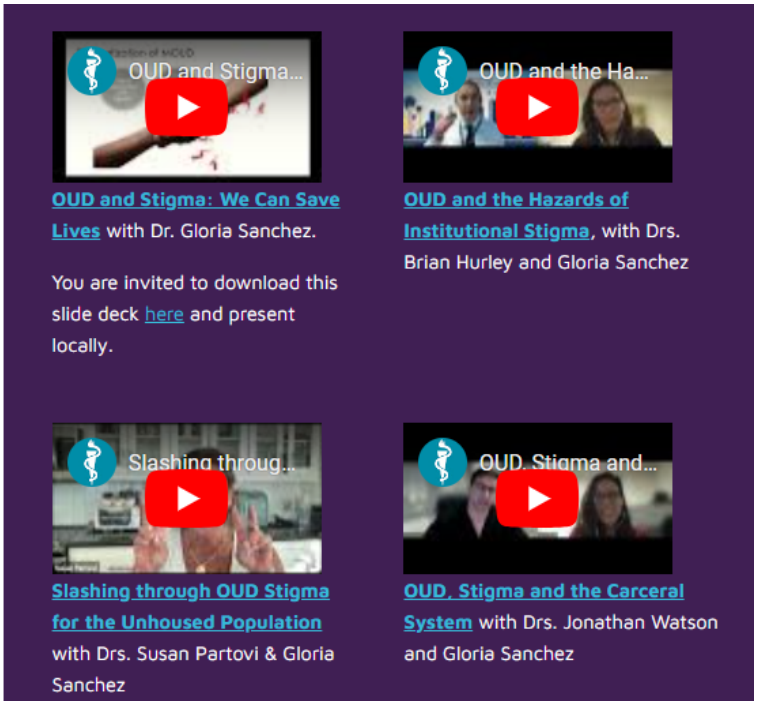
The IPMA Health Equity Roundtable educational sessions provided in CPRC3 grant have helped to effectively equip residency programs with the tools and knowledge needed to advance health equity goals. Participants have reported they are more effective in their ability to integrate these goals into their SUD treatment programs, highlighting the program's value. This training is essential not only for immediate improvements in treating substance use disorders but also crucial for addressing the broader needs of underserved populations.
Furthermore, the skills and knowledge acquired through these sessions are highly transferable and invaluable for future healthcare work. Professionals trained in these programs are better prepared to identify and address health disparities, utilize strategic frameworks like the CMS Disparities Impact Statement, and implement comprehensive action plans. Expanding and delivering more educational programs of this nature will be vital in cultivating a healthcare workforce proficient in advancing health equity, ultimately leading to substantial and sustainable improvements in patient care and health outcomes across the healthcare system.

Educational Resources on Stigma

Working with CRPC grantee Gloria Sanchez, MD, FASAM, we developed a package of resources to address stigma associated with OUD. These resources include four short videos, as well as an annotated slide deck, to empower champions to educate their own colleagues locally. These materials are now available to grantees through our portal and are available to the general public via https://familydocs.org/sud.

Series Title: *Voices of Stigma*

- Dr. Gloria Sanchez, "OUD and Stigma: We Can Save Lives" With assistance from Dr. Clay Thibodeaux, Dr. Marina Costanza, and Dr. Jonathan Vargas. 20 minute video & annotated slide deck
- Dr. Brian Hurley & Dr. Gloria Sanchez, "OUD and the Hazards of Institutional Stigma." 14 minute video
- Dr. Susan Partovi & Dr. Gloria Sanchez, "Slashing through OUD Stigma for the Unhoused Population." 24 minute video
- Dr. Jonathan Watson & Dr. Gloria Sanchez, "OUD, Stigma and the Carceral System." 29 minute video

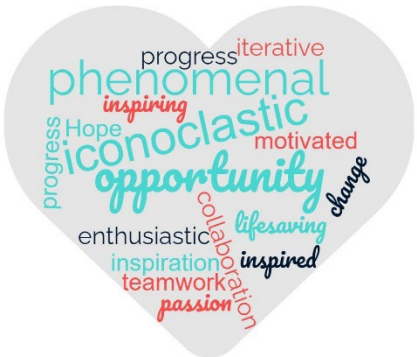


CRPC Meetings & Webinars

Below is a summary of the meetings and webinars, in date order, conducted during this learning collaborative. Each session offered education and opportunities to collaborate with fellow grantees. If requested, we are happy to provide the complete agenda, presentation and resources used for each session.

April 22, 2023 – Full Grantee in person 5-hour Meeting in Sacramento

The first full grantee meeting was held in Sacramento. We had active engagement and participation from the 49 participants - all 25 residency programs were represented - as well as members of the EAP and staff. The agenda included an overview of the California OUD-SUD/Addiction/MAT landscape by Dr. Aimee Moulin, Professor, UC Davis and the UC Davis Emergency Department Behavioral Health Director along with brief presentations by each of the grantees about their projects. We also provided an introduction to Quality Improvement, reviewed the many tools and resources available, heard from prior CRPC-1 & 2 grantees sharing their experience and advice for getting the most out of this collaborative and broke into small groups based on the grantee proposals so that grantees could share information, resources and anticipated barriers and challenges from the very beginning of the collaborative.

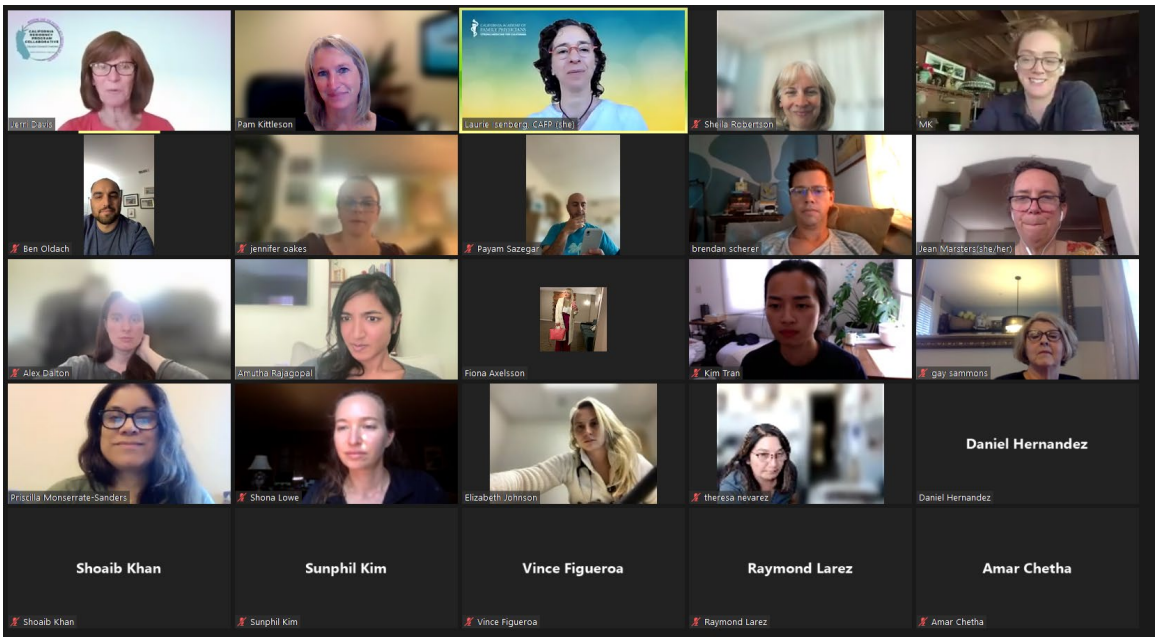


The final "One Word Reflection" where we asked learners to provide us with one word about how they felt after the session is reflected in the wordle image to the right here. We were off to the races!

CRPC-3 Kick Off Meeting

June 14, 2023 – Lunch and Learn 1 hour Virtual Workshop

Our next meeting (after the Health Equity in person meetings described above) was held in June with active engagement and participation from the 50 participants – 23 of the 25 residency programs were represented - as well as members of the EAP and staff. At this session, we discussed the Framework developed to demonstrate more effectively the data we are collecting in this collaboration. Our goal was to ensure all grantees understood what we were collecting and why and also find out if we could help with any barriers to collection. We provided the grantees with useful information and resources from our Quality Improvement Project and then had a long discussion about how to increase provider engagement. We recorded the webinar and made the full meeting available to grantees on the private CRPC website along with meeting and chat notes.



Live virtual Webinar - June 21st, 12 noon - 1 PM - *View From The Street*

A week after our first virtual CRPC Webinar, we presented a public live webinar co-presented by one of our very own CRPC grantees, Rebecca Trotsky-Sirr, MD, and she was joined by Sergeant Brian Gunsolley with the Orange County Sheriff's Department. This session described how patients are obtaining Fentanyl and other synthetic opioids and how clinicians can help their patients recognize and understand the dangers of non-prescribed medication as well as encourage the use of reversal agents. In addition, there was discussion around breaking down barriers to increase use of MAT in primary care. We recorded this session and it is still actively available in Homeroom. To date, we have had 60 enrollments and 51.4 percent plan to make changes based on the education received.

Some of the changes these learners indicated that they planned to make as a result of this webinar include:

- ***Expand treatment through:*** Advocating for broader availability of MAT, use more Suboxone, I will be better able to counsel patients and advocate for earlier treatment, allow appropriate patients to begin Suboxone at home, convince patients to seek treatment for substance use disorder, and provide education regarding treatment options available.

- ***Expand harm reduction through:*** Advocating for broader availability of Narcan and fentanyl test strips, Discuss Narcan more often, I plan to obtain Naloxone ASAP and train my office staff as well as family members on how to administer it.

- ***General:*** Inquire more with my teens, provide education, Make patients aware of presence of fentanyl in most of the street drugs and understand it's potency and ability to cause death, Discuss these drugs better with patients

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Creating a very "alive" collaboration with a pediatric clinic that serves very at-risk children with multiple ACES and unmet needs has been amazing! The teens that we have seen after screening are very engaged and willing to discuss sud and any available mat/sud services.

Regional Webinars

We held our first set of regional meetings virtually one week apart, starting with northern California. At each of the three following meetings, we discussed local resources available to grantees and included a "capsule exercise," which is a means of "crowdsourcing" ideas and potential solutions to a problem, project, or question. We broke into small groups and each grantee was able to introduce their problem/concern and get ideas for solutions and feedback from the others in the group. The grantees were so appreciative of this process and took away a lot of great ideas and possibilities for improving their project efforts. We shared the meeting recordings, and the helpful notes from the meetings on the CRPC Private Webpage for all grantees to benefit from.

"This was a very helpful meeting, you guys have been incredible!"

"This was helpful to walk through the data submission and get us started on the QI portal."

"Thank you for helping us build bridges and connections."

Thirty-three attendees completed our regional webinar evaluation and when asked if they were satisfied with the webinar, 45.5 percent were "Extremely" satisfied and 54.5 percent were "Satisfied." We asked what topics they would like to learn more about from us and they responded with things like: stigma, examples of successes and failures with MOUD, evidence behind MAT screening tools, examples of how to approach the QI project, harm reduction and ideas for following up with patients. When asked what they'd like CRPC's help with, they replied: Ideas for implementing case managers, substance use navigators, how to open/fund a harm reduction clinic, funding sources to hire MAT champions at all levels: MD, PA/NP, SW, SUD Counselors, and create a "Resource Library" for grantees and others to share helpful resources. It was this suggestion that led to our Resource Library on the CRPC Private Page.

July 12, 2023 – 2-hour Northern CA Virtual Webinar

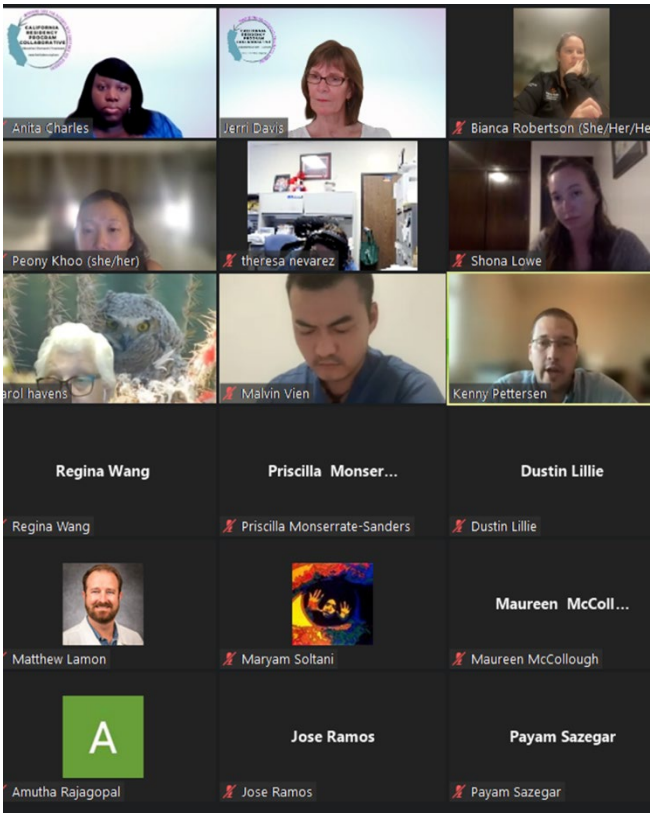
We held our first regional webinar with 10 northern California grantees: Contra Costa Regional Medical Center FMRP, County of San Mateo/San Mateo Psych RP, Fourth Second: One Love Vallejo Mobile Health, Highland Hospital/Alameda Health System EMRP, San Joaquin General Hospital FMRP, Shasta Community Health Center FMRP, Sierra Nevada Memorial Hospital FMRP, St Joseph's Stockton EMRP, UC Davis EMRP, and UC Davis FMRP. There was robust and active engagement from the 16 attendees. We heard from CRPC-1 & 2 grantees that shared advice, and discussed sustainability and also asked grantees to share one success with their project so far.

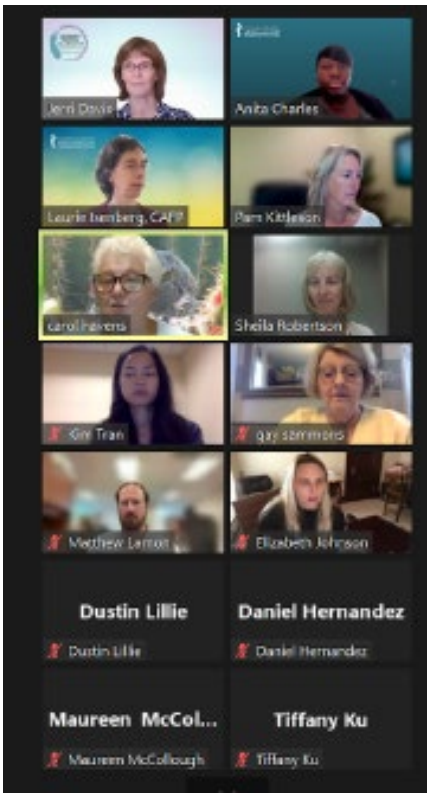
July 19, 2023 – 2-hour Central CA Virtual Regional Webinar

Our next regional meeting included our 5 grantee programs from Central California: Adventist Health Hanford FMRP, Adventist Health Tulare FMRP, Kern Medical Center IMRP, Rio Bravo FMRP, and UCSF Fresno FMRP. There was robust and active engagement from the 14 attendees. They enjoyed sharing their one success and the capsule exercise was very helpful to them. We shared the meeting recording, and the helpful notes from the meeting on the CRPC Private Webpage for all grantees to benefit from.

July 26, 2023 – 2-hour Southern CA Virtual Regional Webinar

Our next regional meeting included our 9 grantee programs from Southern California: California Hospital Medical Center FMRP, Harbor UCLA FMRP + PEDs RP, Harbor UCLA IMRP + FMRP, Kaiser San Diego FMRP, Olive View-UCLA Medical Center EMRP, Pomona Valley Hospital Medical Center FMRP, UC San Diego FMRP, UC San Diego IMRP, and Ventura County Medical Center FMRP. There was robust and active engagement from the 17 attendees. The capsule exercise was very helpful to them, along with a review of all the CRPC resources and this small group could really discuss more local resources available as well. We shared the meeting recording, and the helpful notes from the meeting on the CRPC Private Webpage for all grantees to benefit from.





September 13, 2023 – Lunch and Learn 1 hour virtual Workshop

Our next virtual webinar was attended by 35 grantees. We included time on the agenda for those grantees that attended the CA Society of Addiction Medicine (CSAM) meeting the prior month, as well as the CAFP's Family Medicine POP conference, to share their key "takeaways" from the conferences. We then went into small groups and let grantees choose which groups to join below based on their interest:

- ❖ Education Program development
- ❖ Harm Reduction
- ❖ Street/Unhoused Medicine
- ❖ Recruiting MOUD Champions
- ❖ Addressing Stigma

Some of the resources/information shared included in the small groups included:

- Microsoft Planner (institutional license) project management software for delegating tasks/work items for grant deliverables
- MICaresed.org for educational resources and assistance with practice pathway boarding
- IM Addiction Medicine podcast for trainees and faculty
- Info on syringe Services Programs (SSPs): https://www.cdc.gov/ssp/index.html
- https://erowid.org/ for info on psychoactives
- Addiction Medicine Toolkit for Health Care Providers in Training at NIDA: https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/addiction-medicine-toolkit-health-care-providers-training
- San Francisco Department of Public Health website
- Stigma small group: "higher ups" in hospitals not familiar with non-stigmatizing language, hard to reach certain hospital staff for education sessions, poor survey, response rate, and restricting policies such as not allowing buprenorphine prescriptions in the hospital.
- Education group. Obstacles: have an addiction specialist available to provide guidance, getting over the fear of the initial prescription

There were also questions around the Federal MAT/MATE Act and what counted toward the mandatory 8 hours of education before renewing a DEA license. We provided broad guidance from SAMHSA.

One of our faculty who was inspired by the learning during the fellowship is now leading policy change in the hospital to improve care for patient in perinatal/neonatal period.

Two of our faculty fellows are engaged in revisiting the conversations with local CPS to destigmatize and improve care for patient with SUD in the perinatal period.

October 7, 2023 – 4-hour Full Grantee Virtual Webinar

We held a half-day full grantee virtual meeting with presentations from the CA State Association of Counties (CSAC) and Mario San Bartolomé, MD, MBA, MRO, FASAM, one of our MOUD Champions, an update on QI activities, a summary of data collected to date, presentations from three of our grantees about their projects, a review of our collaborative resource sharing efforts and finally, small group discussion about helping grantees continue to succeed with their projects.

Grantees expressed their appreciation for the very helpful information that "Dr. Mario" shared and the tips and useful resources that the three grantee programs shared and that are included in the CRPC Resource page linked on the private website. We recorded the presentation "MAT and Complex Patients" presented at this webinar and it is still available in Homeroom. To date, eight additional learners have accessed Dr. San Bartolome's presentation. Their evaluations show consensus that the material will help make them more effective in their practice and that they are confident that practice change will result.

December 6, 2023 – Lunch and Learn 1 hour Webinar

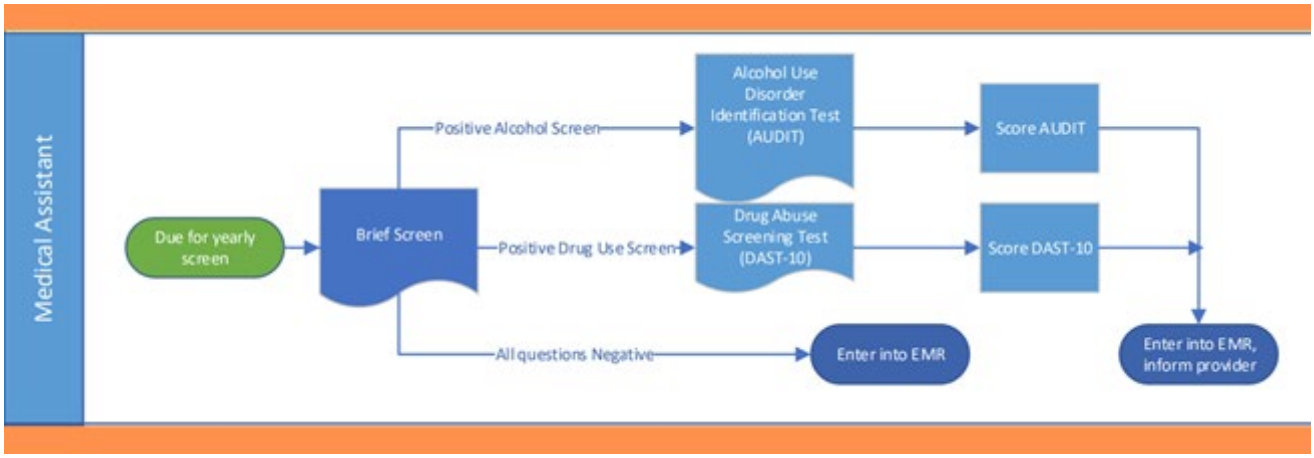
This webinar included presentations by Elissa Feld, MPP, Senior Policy Analyst, County Behavioral Health Directors Association (CBHDA), CA Hospital FMRP and UCSF Fresno FMRP.

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

OVERVIEW OF OPIOID SETTLEMENT FUNDS

December 6, 2023

Grantees appreciated the update regarding CA opioid settlement funding and insights from CBHDA about the importance of connecting with the right people locally to sustain the great work they are doing in the community. The two grantees presented excellent resources that we know will be used by others based on the conversation and appreciation expressed at the meeting. The sample workflow (see image here), specifically, that Dr. Khoo shared from Eisner Health and the CA Hospital FMRP was a highlight for attendees. Evaluations from this meeting were very positive and we gathered specific information from grantees about what topics we should cover at our upcoming regional meetings being held in January.

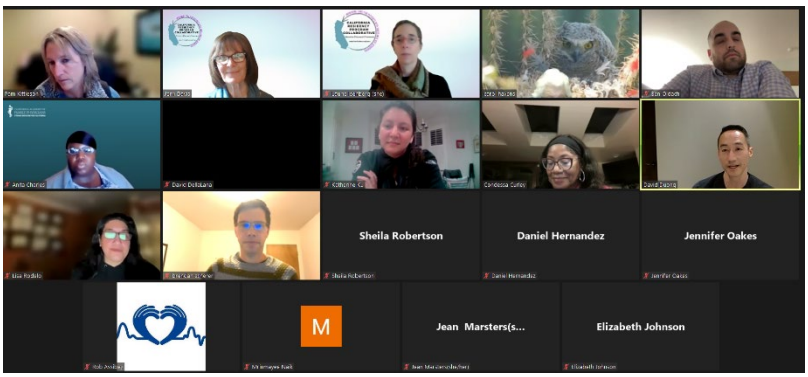


Second Round of Regional Webinars

We held our second set of regional meetings virtually one week apart, starting again with northern California. Since grantees have made it clear that one of the best ways we can help them is by freeing up time for them to collaborate with their fellow grantees, each of the three following regional meetings included "capsule time" again to collaborate and a discussion of resources available and needed.

January 17, 2024 – 2-hour Northern CA Virtual Webinar

We held our second regional webinar with 8 northern California grantees: Contra Costa Regional Medical Center FMRP, County of San Mateo/San Mateo Psych RP, Highland Hospital/Alameda Health System EMRP, San Joaquin General Hospital FMRP, Sierra Nevada Memorial Hospital FMRP, St Joseph's Stockton EMRP, and UC Davis FMRP. There was robust and active engagement from the 19 attendees. We heard from CRPC-1 & 2 grantees that shared advice, and discussed sustainability and also asked grantees to share one success with their project so far.



January 24, 2024 – 2-hour Central CA Virtual Webinar

We held our second regional webinar with 5 southern California grantees: Adventist Health Hanford FMRP, Adventist Health Tulare FMRP, Kern Medical Center IMRP, Rio Bravo FMRP, and UCSF Fresno FMRP as well as 2 northern California grantees that we invited to join: UC Davis EM and Fourth Second: One Love Vallejo Mobile Health. There was robust and active engagement from the 17 attendees.

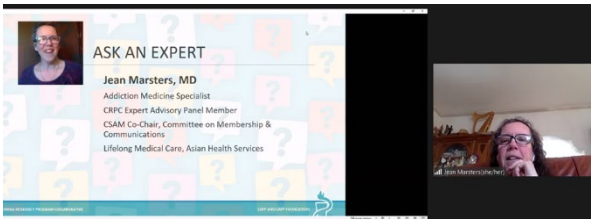
January 31, 2024 – 2-hour Southern CA Virtual Webinar

We held our second and final regional webinar with 9 grantee programs from Southern California: California Hospital Medical Center FMRP, Harbor UCLA FMRP + PEDs RP, Harbor UCLA IMRP + FMRP, Kaiser San Diego FMRP, Olive View-UCLA Medical Center EMRP, Pomona Valley Hospital Medical Center FMRP, UC San Diego FMRP, UC San Diego IMRP, and Ventura County Medical Center FMRP. There was robust and active engagement from the 17 attendees.

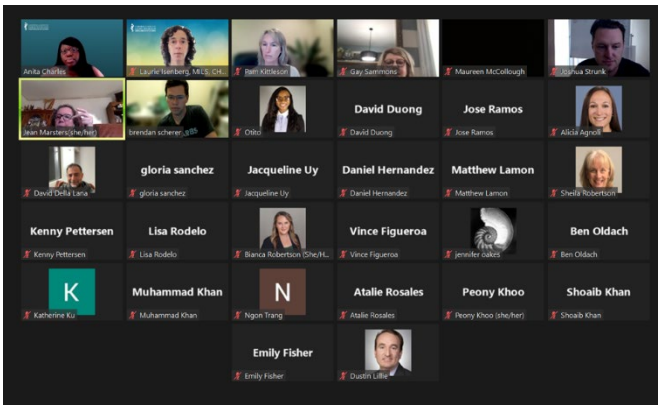
March 13, 2024 – Lunch and Learn 1 hour Workshop

We had 37 attendees at this lunchtime webinar representing nearly all grantee programs. The following topics were addressed in detail:

- Presentation of sustainability resources from DHCS, local governments, and foundations
- *Voices of Stigma* project (see above) from grantee Dr. Gloria Sanchez with suggestions of how this new resource could be leveraged in different grantee environments



· Development/Sharing opportunities at August CSAM conference and scholarships through MERF
· Review of remainder of program events and milestones

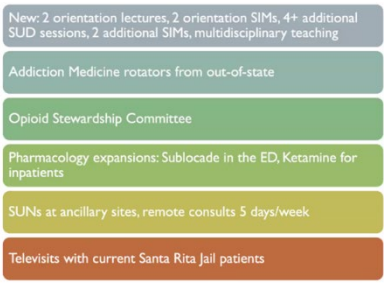


Expert Advisory Panel member Dr. Jean Marsters led a Q&A session with rich discussion on a range of topics, including the implementation of the living library of shared grantee resources on the CRPC private webpage that was suggested at a previous meeting.

The evaluation from this meeting (n=12) showed that 66.7 percent of attendees were "extremely" satisfied with the meeting and 25 percent were satisfied. 100 percent of the attendees indicated that they plan to access and use the resources made available on the private CRPC website.

We asked "Anything else on your mind you'd like to share?," grantees replied:
"Excellent presentation and Q&A session"
"Great program!! Love the ability to collaborate and share resources"
"Thank you for all the resources!"

April 17, 2024 – 1.5 hour Health Equity Webinar



This session is also described above in the "Health Equity Education" section. 37 attendees discussed the successes and challenges of the past year, including cultural and logistical barriers, and shared strategies developed to enhance the integration of health equity into their projects. Several grantees shared their experiences, insights, and successes. Some of these included establishing an opioid stewardship committee, standardized screening of adolescents, increasing the number of residents exposed to working with carceral population (and who now prescribe buprenorphine) from 1 to 6, and removing suboxone restriction in formulary. The collaborative nature of the webinar facilitated a rich exchange of ideas and experiences, aimed at

fostering ongoing improvement and innovation. There was also great interest in publishing a poster or paper describing the success of this collaboration.

May 22, 2024 – 1 hour Optional "Office Hours" Webinar

We held another lunchtime webinar on May 22, giving grantees the option to join and ask questions of the CRPC management team as they conclude their projects and prepare their final reports. We had a few programs join to ask questions around budget reconciliation, data reporting and sustainability.

FINAL CONVOCATION

June 7, 2024 – 5 hour in person meeting (Convocation)
Waterfront Hotel, Oakland, CA

What a fantastic celebration we had with the 36 attendees at our Convocation. It is a very busy time of year for residency programs and four of our grantee programs were unable to attend. The other twenty-one programs, however, spent time sharing the highlights of their projects and what they've accomplished and learned.

CRPC-3 Convocation

HOMEROOM – ENDURING EDUCATION

Homeroom. We are pleased to report that we have fifteen enduring educational activities available in the publicly available CAFP Learning Management System (LMS) "Homeroom" supporting this collaborative at https://education.familydocs.org/.

Twelve of these activities are accredited CME sessions, continuing to offer a total of 12.50 CME Credits to learners, and three are non accredited educational sessions. All are available 24/7 to grantees and others. Here, we are providing a broad range of the educational content.

Educational Offerings in Homeroom:

- Addiction Medicine is Family Medicine (.75 CME)
- Call to Action: The Time for Treating Substance Use Disorder is Now
- Screening and Identifying for Opioid Use and Substance Use Disorders (.5 CME)
- Pain Management and Opioids: Balancing Risks and Benefits (3 CME)
- Pregnancy and Women's SUD (.75 CME)
- Break the Stigma, Save a Life (1 CME)
- Telehealth for Substance Use (.5 CME)
- Medication Assisted Treatments for Opiates, But What About Stimulants: An EBM Literature Review (1 CME)
- OUD and Stigma: We Can Save Lives
- Opioid and Substance Use Disorders in Special Populations: Youth and Young Adult Athletes (1.25 CME)
- Prescribing Medication for Opioid Use Disorder (1 CME)
- Communication Matters: Motivational Interviewing and Substance Use Disorder (.75 CME)
- The Time for Treating Substance Use Disorder is Now (1 CME)
- MAT and Complex Patients: Addressing Provider Concerns
- The View from the Street: What Physicians need to know about Fentanyl and Illicit Drugs (1 CME)

These activities will continue to offer CME credit through August 2024 and be available to learners through the end of the year.

I finally saw our first adolescent patient referred to our addiction medicine clinic after they were seen and screened in the residency clinic! It was expedited and we are starting her on medication, results pending. I think this is the result of the efforts put into training residents to be comfortable screening for adolescent substance use and referring promptly when appropriate.

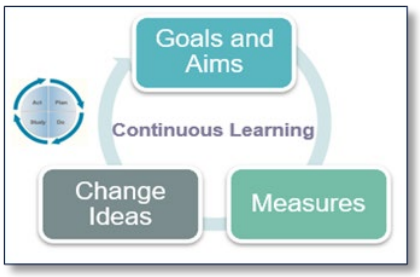
Case Information: Mid 20s patient was connecting to outpatient clinic – she carries a psychiatric history of schizophrenia, depression, and anxiety as well as polysubstance use(methamphetamine, nicotine, opioids). She was currently transitioned to Sublocade while at the local county jail.

MAINTENANCE OF CERTIFICATION (MOC) AND QUALITY IMPROVEMENT (QI)

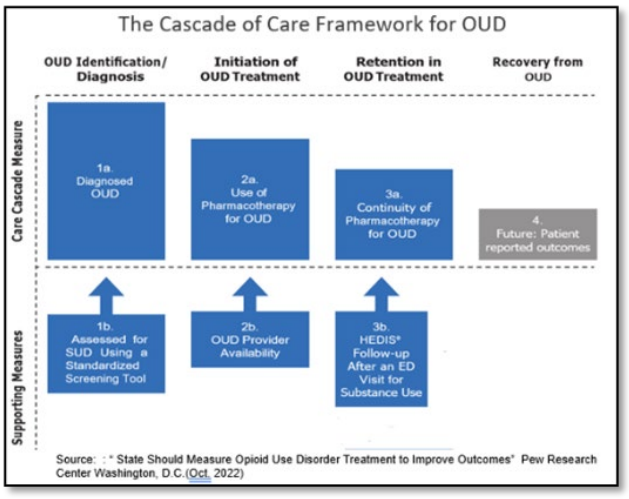
Supporting Practice Transformation through Quality Improvement

Background

IPMA, in collaboration with CAFP, contributed to the *Education, Outreach, and Treatment: Improving Care for Patients with Substance Use Disorder* grant by developing a program to support practice transformation through quality improvement. The program support included quality improvement (QI) education, customized coaching, quality improvement resources, and tools to help plan and implement change. The overall transformation process provided a structure for awardees to work through the implementation of their projects and promote sharing among residencies even as specific implementation and challenges varied. IPMA developed a quality improvement module to support Emergency Medicine, Family Medicine, Internal Medicine, OB/GYN, Pediatrics and Psychiatry residency programs. The project was approved for MOC part IV credit from the American Board of Medical Specialties (ABMS) and provided CME credit.



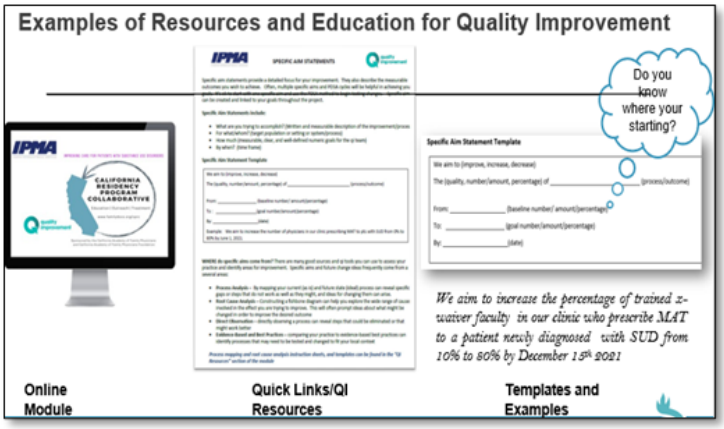
The quality improvement module was designed to assess program readiness for change and provide the framework for linking strategic SMART goals to specific aims (changes in practice) that lead to improvements in their daily work. It is aligned with the Model for Improvement but was not meant to replace change models programs may already be using. Instead, it aims to accelerate improvement and increase the likelihood of making sustainable changes in practice. A literature review was done to assess meaningful measures applicable to primary care and emergency medicine practices. As a result, learners were introduced to the "*Cascade of Care Framework for OUD"* as a model for aligning their Quality Improvement initiatives. Candidate quality measure concepts for various stages at structural, process, and outcome levels were identified. Developing and organizing quality measures under this framework helped practices identify existing quality measures relevant to the context of their programs and identified future measures to work on through the continuum of care for OUD treatment once that goal has been met. Central to the program's support was the availability of a quality improvement coach. The QI coach developed a standardized check-in process and was a resource for the programs to access throughout the grant cycle. The QI coach met individually with residency program contacts to assess practice improvement and provided customized coaching to guide them through the improvement process.



The Improvement Process

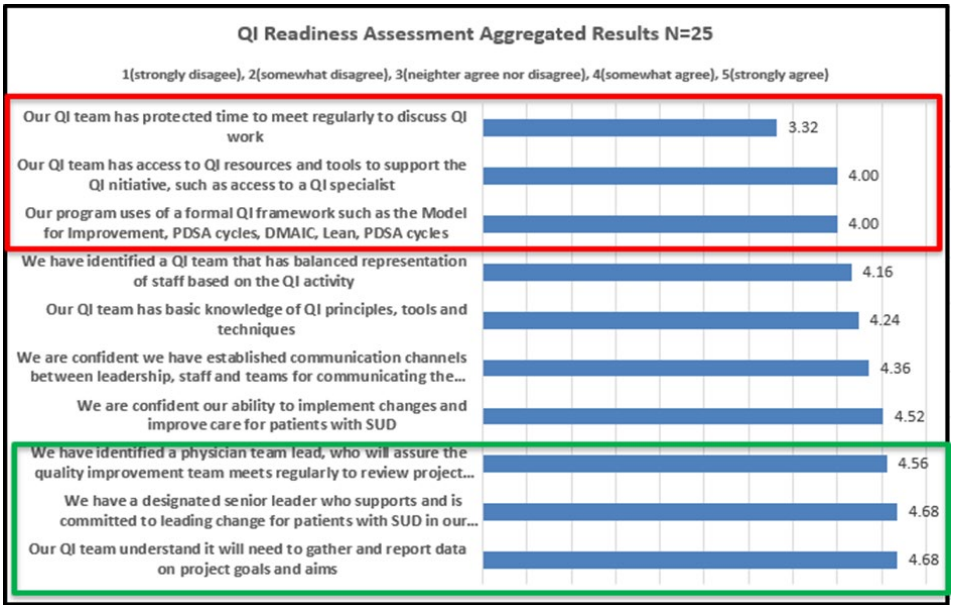
The QI process starts with learning about the principles of quality improvement. An online module was designed to guide teams step by step using the Plan-Do-Study-Act (PDSA) quality improvement framework. Quality improvement education, tools, and templates were embedded.

Team leads from each program began with a QI readiness assessment that identified critical foundational elements for engaging in quality improvement areas. Next, programs created a work plan that identified project goals and aligned them with the creation of specific aims statements to focus their improvement work. The specific aim statements were detailed written statements of how programs intended to meet their goals, including processes, populations, measurements, and time frames. Teams identified and clarified their measures by documenting the measure title, numerator, and denominator used to calculate performance and began collecting baseline data. As part of the QI education, teams were encouraged to assess current practices to help identify changes and areas for improvement. Process mapping and root cause analysis instruction sheets and templates could be found in the "QI resources" section of the module. After baseline data were collected, teams identified actional change ideas. Separate, distinct change ideas rather than adding them as a group helped the team determine each change idea's effectiveness in supporting the quality improvement aim. Teams then planned out their project and conducted small tests of change using the PDSA cycles. Teams completed two PDSA cycles during the course of their project. The PDSA cycles were about learning what works and what does not in their efforts to improve processes. After each cycle, teams studied and analyzed to see if their changes led to improvements and impacted their objective. As part of the process, teams were encouraged to capture and document a patient story to inspire their improvement work and upload documents, photos, and videos of their improvement journey to share with the collaborative during live webinars. The completed module could be used to track and share progress on your quality improvement story with other team members and leadership. At completion, all members of the QI team were eligible to receive CME and Board activity points for participating in the quality improvement project.

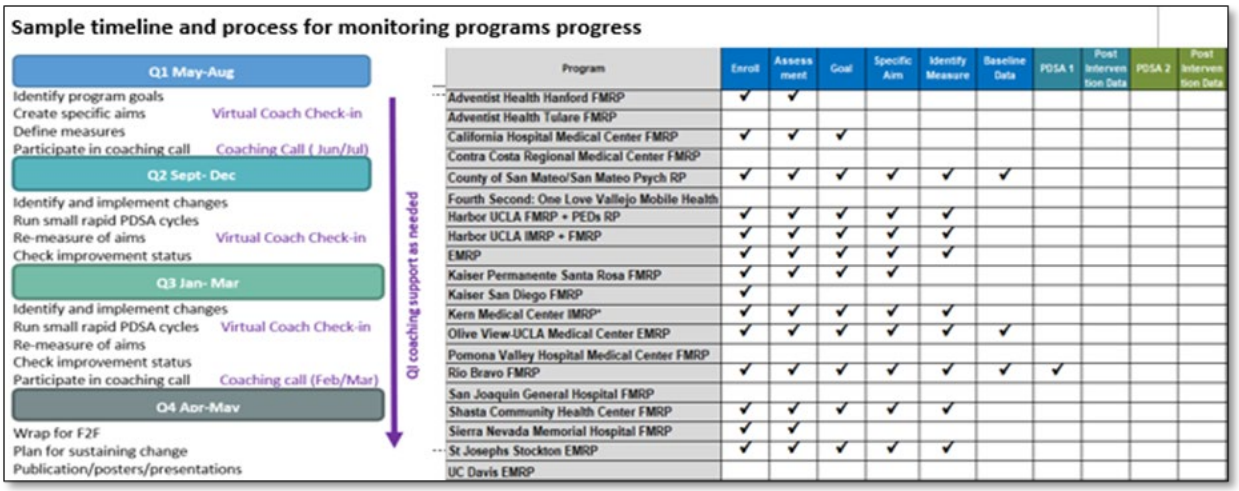


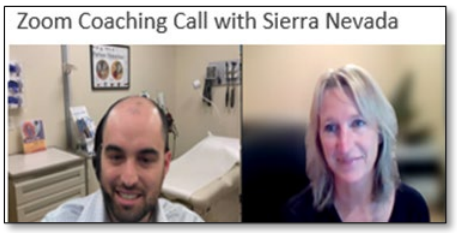
Facilitating Improvement and Guiding Practices through Practice Transformation

Team leads from each program were asked to complete a QI readiness assessment that identified critical foundational elements for engaging in quality improvement areas. The assessment was used to help facilitate improvement and assure successful implementation of quality improvement work. It provided both practices and grant administrators with a scan of available resources, data access, the overall residency function, and QI knowledge and experience. The assessment was administered early in the project and completed by the Team Lead for each program. Results highlighted the variation in the foundational elements across and within the 25 programs. As a collaborative, the programs scored highest in agreement when they identified a team lead, and senior leader who supports the QI work and is committed to leading change. They also understood the need to collect data for improvement. The biggest opportunity was to help teams find time to discuss QI work and provide access to QI resources and support. Findings were used to inform coaching strategies with the individual programs.



The QI coach developed a timeline and standardized check-in process for the residency programs.

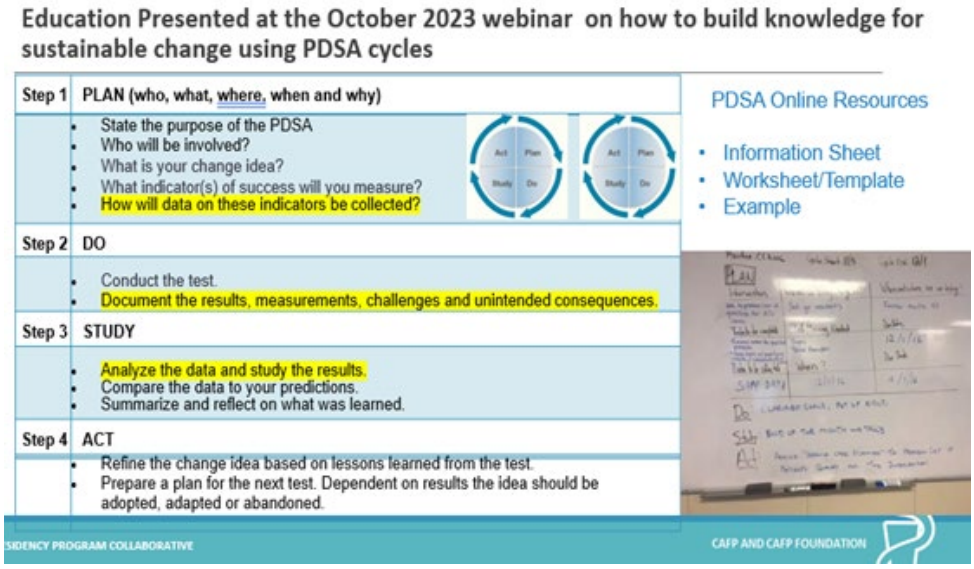




The check-in process included two customized coaching calls and three virtual check-ins to assess practice improvement towards their goal. Programs were invited to participate in customized coaching calls twice throughout the grant period. The calls were scheduled for 30 minutes and lasted anywhere from 20-60 minutes depending on needs. During the call, the QI coach check-in to assist with questions about the QI framework and discuss progress, barriers, and next steps. Common themes from the coaching calls included clarification of specific aims, the importance of gathering baseline data before making changes, clarification on measure definition, and the importance of operational definitions to clarify the data collection process.

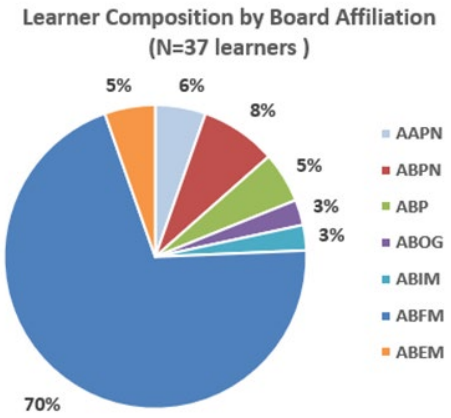
Educating and Supporting the QI Process at Live Meetings and Webinars

Education on quality improvement was reinforced at webinars and live meetings. The quality improvement education was launched through the April 2023 all-team kick-off webinar. The objectives were to illustrate the QI framework adopted for the project, including the timeline, educational module, one-on-one coaching, and reporting process. Review and identification of best practices for relevant measures, steps to meet the MOC Part IV requirements, and QI resources to support the projects were also highlighted. Additional resources and QI education were provided through the remaining webinars and regional meetings throughout 2023 and 2024. Areas of focus included creating SMART goals and specific aim statements, parts of a measure and creating a data collection plan, and an introduction on how to plan and implement PDSA cycles. Collecting patient stories was encouraged throughout the process and shared at the final convocation meeting. Sharing patient stories was a way to put the human face to the data being collected in ways numbers cannot. Team leads were encouraged to discuss at team meetings to help connect to the day-to-day process and with leadership to help focus on why they are doing the work. Patient stories were collected and shared at the final convocation in June 2024.



Results

All 25 teams (100%) enrolled in the quality education module. Twenty programs completed the online module for CME and MOC Part IV credit. One hundred and three learners were identified as being part of their programs quality improvement teams. Quality education and improvement learnings go beyond what was captured in the online module. To date, 75 learners have requested CME and MOC Part IV credit through their member Boards for their participation in the quality improvement initiative. Thirty seven learners representing 7 multi-specialty boards have received CME and MOC Part IV credit.



Teams were coached to break down work processes and outcomes into identifiable and measurable PDSA cycles, with teams recognizing that multiple aims could be needed to reach their intended goal(s). As a result, more than 25 specific aims appropriate for the individual program's context were identified as improvement areas. All the aims contributed to the OUD/SUD landscape and aligned with the collaborative overall objectives to identify those in need of treatment and to initiate/engage and sustain individuals in treatment. Examples of improvement over baseline include:

Increases in patients screened:

17%, 33%, 55%, 100% ↑
20% ↑ alcohol use screening
31% ↑ screened with CRAFFT

Teams with increases in OUD/SUD Management:

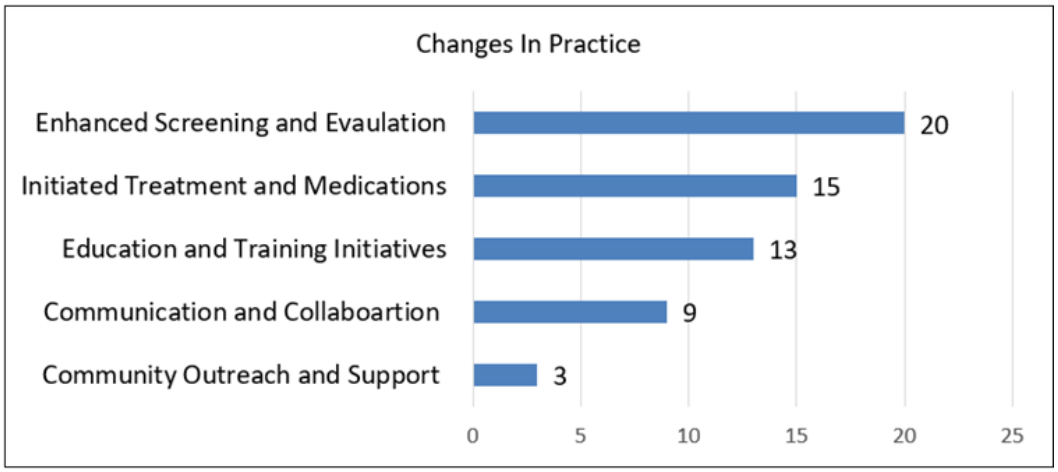
41%, 100% ↑ trained on MAT
67%, 84% ↑ patients received MAT
38% ↑ inmates receive OUD care
15% ↑ ED SUD pts f/u in 30 days
1.44 ↑ MAUD rx/month in PC

Qualitative assessments were analyzed to provide value-added feedback to the program. The following summarizes the findings to date from the 37 respondents.

Changes in Practice

A wide range of initiatives were aimed at improving the screening and treatment of substance use disorder (SUD). These initiatives include expanded coverage for inmates with opioid use disorder in county jails, standardized screening and referral practices, increased access to medication-assisted treatment (MAT) services, and educational efforts for residents and providers on addiction medicine. Other activities involve enhancing communication, improving access to MAT services, and reaching out to SUD patients within the community. Altogether, these efforts signify a dedicated approach to enhancing SUD screening, providing relevant interventions, and advancing patient care.

Summary of responses identifying changes made in practice



Examples that represent the different focus areas and strategies employed to address substance use disorders within the practice:

1. Enhanced Screening and Evaluation:
   - Expansion of coverage in the county jail for inmates with opioid use disorder
   - Implementation of consistent screening practices for substance use disorders
   - Increased screening for drug and alcohol use in various patient groups

2. Treatment and Medication:
   - Increased use of buprenorphine for opioid use disorder and chronic pain management
   - Implementation of medication-assisted treatment (MAT) for alcohol and opioids
   - Improving follow-up and treatment for substance use disorders

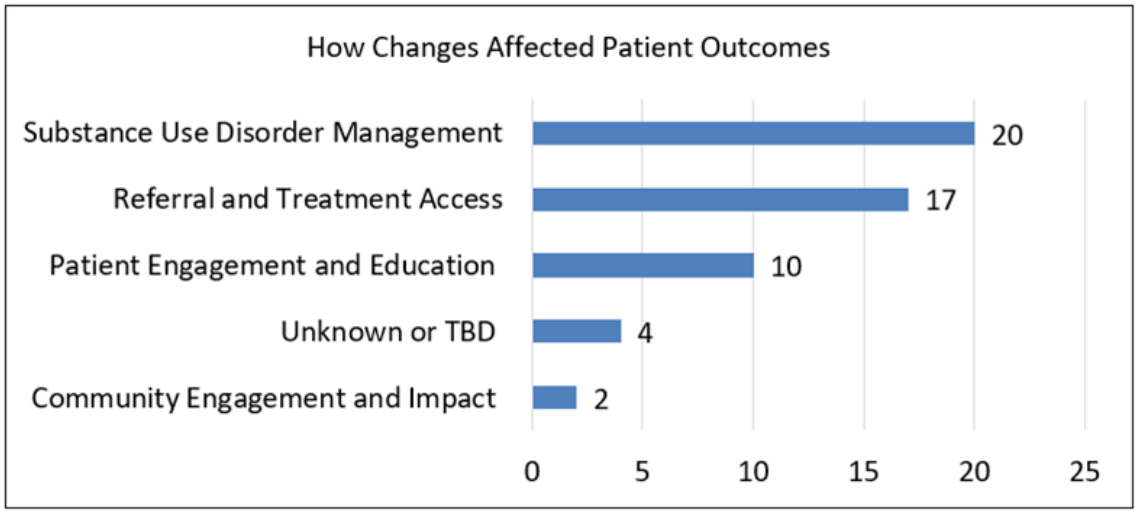
3. Educational Initiatives:
   - Integration of substance use disorder curriculum into medical practice
   - Introduction of addiction medicine curriculum and resources for residents and students

4. Communication and Collaboration:
   - Improved communication between medical assistants and providers for follow-up and referrals
   - Direct communication between different healthcare professionals upon positive substance use screening

Patient Outcomes

Substantial progress has been made in the treatment of patients with substance use disorders. The advancements include enhanced patient engagement, the implementation of more effective screening pathways, improved access to treatment, better diagnosis and referral processes, increased access to Medication Assisted Treatment, and reduced wait times for addiction specialists. These positive changes have resulted in increased referrals for substance abuse treatment, improved patient access to harm reduction services, and higher rates of patients entering recovery. It is apparent that these efforts have had a significant impact on the care and outcomes for patients with substance use disorders.

Summary of responses identifying how changes made in practice affect patient outcomes



Examples of responses that represent the key areas of how changes affected patient outcomes:

1. Substance Use Disorder Management:
   - Improved identification of patients with alcohol overuse issues and improved selection of patients for targeted brief counseling and intervention(s)
   - Patients with substance use disorders treated in a non-judgmental way
   - Increased detection to reduce barriers to effective treatment

2. Referral and Treatment Access:
   - Increased referrals for substance abuse treatment and harm reduction
   - Shorter wait times for addiction specialists and access to resources for recovery
   - Referral to Medication Assisted Treatments (MAT)
   - Increased access to MAT

3. Patient Engagement and Education:
   - More time spent with patients to improve understanding of treatment
   - Use of motivational interviewing and psychoeducation
   - Patients seem engaged and willing to discuss follow-up options

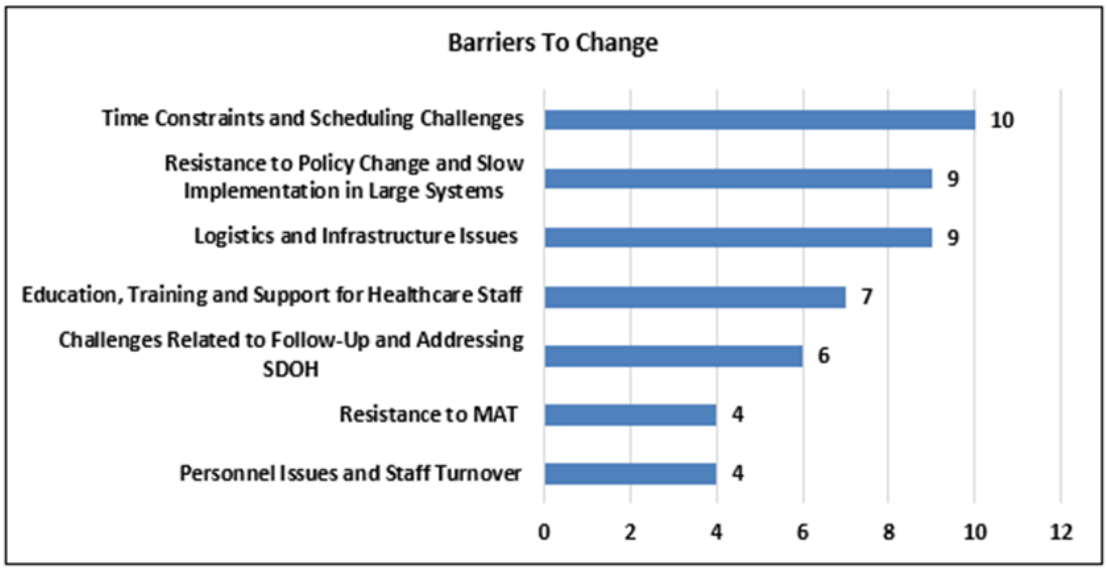
4. Community Engagement and Impact:
   - Engagement of patients from the community who may have never been informed of treatment options
   - Successful transition of patients to Suboxone and local rehabilitation programs

We created a patient centered street medicine outreach clinic with an expanding census and sustained ability for future growth in the form of a permanent longitudinal elective rotation, serving our most vulnerable patient has Alameda county with substance use disorder and despair he has no social determinants of health.

Barriers

The programs encountered several significant challenges, including time constraints, staff turnover, resistance to change, difficulties in accessing resources, EMR system issues, and barriers to patient follow-up. These obstacles have hindered the effective implementation of new interventions and the provision of adequate care for patients with substance use disorders. In addition, logistical concerns, lack of support, and limitations in collaboration with other organizations have presented significant hurdles. Enhanced training, education, and resources are needed to address these challenges and ensure the delivery of equitable care to patients

Summary of responses identifying barriers and challenges



Examples of findings classified into several categories based on the barriers and challenges:

1. Time Constraints and Scheduling Challenges:
   - Difficulty in scheduling patients back in a timely manner due to full schedules
   - Time constraints in office visits, limiting the ability to address certain issues
   - Time constraints in contacting MAT clinics for each patient with a positive CRAFT

2. Resistance to Policy Change and Slow Implementation in Large Systems:
   - Marked resistance to policy change in the hospital, affecting the implementation of the newborn policy
   - Slow to implement changes in large systems due to historic culture and implicit bias
   - Resistance from faculty and residents to incorporating CRAFFT tool into practice and challenges in getting IT support for system-wide integration

3. Logistics and Infrastructure Issues:
   - Challenges in obtaining approval for harm reduction vending machines and navigating MediCal enrollment processes for uninsured patients
   - Infrastructure and burnout impacting the delivery of care and implementation of interventions
     - Logistics issues affecting the conduct of ACEs screening in street medicine clinics

4. Education, Training, and Support for Healthcare Staff:
   - Barriers related to EMR system education and staffing, impacting the adoption of new screening tools and interventions
   - Need for educating faculty and residents on the CRAFFT tool and addressing stigma that prevents equitable care

5. Challenges Related to Patient Follow-Up, Referrals, and Addressing Social Determinants of Health:
   - Patients missing appointments due to transportation or communication issues, leading to challenges in providing care:
   - Numerous competing priorities for clinician time and focus, impacting patient follow-up and referrals for behavioral therapy
   - Poor patient follow-up from the emergency department to the family medicine clinic

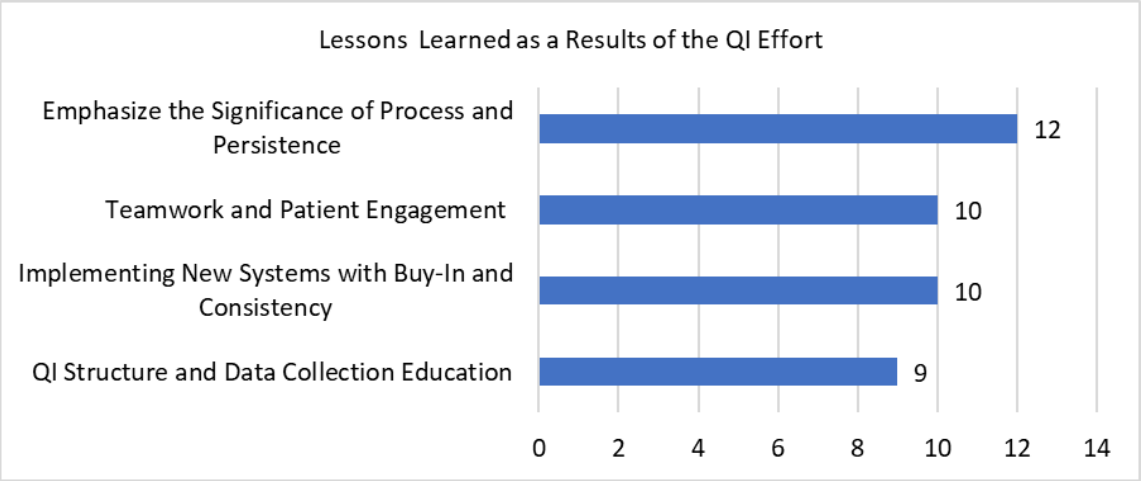
6. Barriers Related to Alcohol Use and Medication-Assisted Treatment (MAT):
   - Challenges in transitioning non-OUD patients from high-risk opioid doses to Suboxone due to suboptimal drug plan coverage
   - Resistance to Suboxone prescribing among core faculty
   - Slow progress toward goals related to addressing alcohol use/initiating MAT for OUD & stimulants

7. Personnel Issues and Staff Turnover:
   - Turnover of healthcare staff impacting training and adaptation of screening and MAT consults
   - Challenges in connecting with planned community partners and personnel issues leading to staff turnover

Lessons Learned

Programs reflected on lessons learned as a result of going through the QI process. Reflecting on the experiences and possibilities help programs to evaluate strengths and weaknesses. It helped programs identify areas for growth and improvement for future work on improving care of patients with OUD. The lessons such as how important communication and collaboration throughout the project and to embed a champion in the clinics can help to speed up future improvements.

Summary of lessons learned as a result of the QI effort include:



Example responses that represent the findings of lessons learned categories:

1. Emphasizing the Significance of Process and Persistence:
   - When physicians start prescribing MAT they are likely to continue prescribing MAT. You just need to get your colleagues to write the 1st prescription in order to move the needle (in a large practice group)
   - Try & Try & Try again. After unsuccessful initial change attempts, our Team re-grouped and brainstormed additional tools and methods to achieve improved outcomes.
   - That change is possible. Sometimes all you need is a nudge to start

2. Teamwork, Patient Engagement:
   - Incorporating community members with lived experience using drugs is an extremely valuable intervention.
   - It takes a whole team to get the job done. Everyone must play their role for everything to be successful.
   - Increasing opportunities to engage patients increased our Tx and or referral success/numbers.

3. Implementing New Systems with Buy-In and Consistency:
   - Implementation of new systems require buy-in and consistency
   - Efficacy of intervention limited by the lack of evidence-based SUD treatment in the community and in the region, making multi-modal (ongoing individual and family interventions) care nearly impossible
   - Negotiation with key stakeholders

4. Quality Improvement (QI) and Data Collection Education :
   - I learned that small wins with actionable interventions can lead to measurable and meaningful change.
   - With a focused QI project we can make a big difference in a relatively short period of time with a collaborative effort
   - Widely accepted data on prevalence rates (or other data for that matter) may not be representative of our own patient population.

Confidence in Making Changes

Additionally, learners were asked on a scale of 1 (not confident) and 5 (very confident) *how confident do you feel in making changes as a result of this quality improvement process*? Thirty-nine learners responded with an **average score of 4.5.** The online module was developed for the multispecialty programs to help assess program readiness for change, introduce and guide them through the Quality Improvement Framework for improvement, and to increase the likelihood of making sustainable changes in practice**.**

Quality Improvement Individualized Coaching Sessions

Learners experience on the Quality Improvement coaching was well received. The participants found the coaching sessions to be exceptionally beneficial in refining SMART goals and objectives for their projects. They emphasized the value of the personalized approach and practical guidance provided, especially in developing metrics for measuring patient outcomes and breaking down targeted projects into achievable steps. The feedback highlighted the role of QI coaching in encouraging critical thinking,

regular tracking of outcomes, and making data-driven decisions. Participants also expressed appreciation for the assistance in adapting to changes, finding practical solutions, and ensuring sustainability of their projects. The coaching was described as invaluable and instrumental in providing a rational framework for leading change, offering insightful feedback, and guiding the participants through project milestones. Overall, the experience with the QI coaching was portrayed as not only positive but also essential for the success and progress of their projects

"The QI coaching was invaluable as it provided us a rational framework for leading change- SMART goals, encouraging critical thinking, regular tracking of outcomes and accountability, making data-driven decisions."

"As a busy primary care clinic with an embedded residency program, it is challenging to find time and personnel who can collect and analyze data from our interventions. The quality improvement coaching helped our team clarify our targeted outcomes and helped us find variables which would be easily captured within our electronic health records without creating a significant documentation burden for the team."

"Coaching was very helpful to encourage breaking our targeted project down to achievable steps to implement. We had a number of steps that we felt would help achieve our goal of increasing first follow up visits. By including periodic check-ins, it helps to keep the physicians in the program who I would imagine are hard-working, way-over-extended to make sure the individual steps of the QI project get completed. I know that was true for me. "

The findings support this approach and indicate a structured quality improvement framework along with individualized QI coaching sessions can be used as a primary approach to make changes to improve the care for patients with substance use disorders.

Next Steps

IPMA continues to support learners in the CRPC3 program and has the online module available through December of 2024. The quality improvement education has given practices the tools and framework to allow them to continue improving the care for patients with substance use disorder beyond the scope of this grant. QI tools and education referenced in this summary can be found in Appendix II.

SUPPLEMENTARY PROGRAMS

Podcasts (https://familydocs.org/podcast)

Podcast Series 1: Treating Addiction in Primary Care

We developed this first podcast series to encourage primary care providers to reach underserved people with Opioid Use Disorder (OUD) through Medication for Opioid Use Disorder (MOUD). The four episodes, launched on March 3, 2023, address the what, the why, and the how of MOUD, helping patient-facing healthcare providers recognize OUD stigma, communicate more effectively, and be more confident in choosing MOUD.

This series was not only supported by the California Department of Health Care Services (DHCS), but also the National Institute on Drug Abuse (NIDA). Below are the titles and participants in the four episodes:

- Episode 1 (186 downloads):
  The Time for Treating Substance Use Disorder Is Now
  Raul Ayala, MD & Arianna Campbell, PA-C
- Episode 2 (197 downloads):
  Break the Stigma, Save a Life
  M. Shoaib Khan, MD, Sky Lee, MD & MK Orsulak, MD
- Episode 3 (161 downloads):
  Prescribing Medication for Opioid Use Disorder
  Tipu Khan, MD & Rebecca Trotzky-Sirr, MD
- Episode 4 (460 downloads):
  Addiction Medicine is Family Medicine!
  Carol Havens, MD & Mario San Bartolome, MD

Podcast Series 2: 1 in 5 series: Stories of doctors and patients reducing harm done by Opioid Use Disorder (OUD)
Released March-April, 2024

In our latest series 1 in 5, released March-April 2024, we published five episodes that bring stories of doctors - and their patients - who have worked together to reduce the harm done by opioid use disorder (OUD). These brief stories take one into the hearts and minds of our guests. Our hope is that this will inspire physicians to do everything in their power to bring medical attention to the OUD patients they serve. The 1 in 5 series interviewer is Dr. Tipu Khan.

- Episode 1 (140 downloads):
  To Help Others Find Doctors Like You: A Patient and Her Doctor Talk MOUD - Gloria Sanchez, MD & Patient Jessica
- Episode 2 (117 downloads):
  The Beauty of the Bus: Meeting Opioid Use Disorder on the Road - Marc Lasher, DO
- Episode 3 (112 downloads):
  From ER to Primary Care: Meeting Patients Where They're At - Karen "Kay" Lind, MD
- Episode 4 (104 downloads):
  I Leaned In: One Family Doc's Story of Treating Opioid Use Disorder - Jay W. Lee, MD
- Episode 5 (84 downloads):
  Addiction Treatment and The Power of Connection - Anusha Chandrakanthan, MD

MOUD Champions

MOUD Champions:
Peer Support for Physicians New to MOUD

New to Medication for Opioid Use Disorder (MOUD)? Do you have questions, or would like a knowledgeable family physician to chat with? Find a MOUD Champion to consult with.

Do you already use Medication for your patients with Opioid Use Disorder? Be a MOUD Champion and share your expertise with peers seeking to build MOUD into their practice.

FIND A MOUD CHAMPION

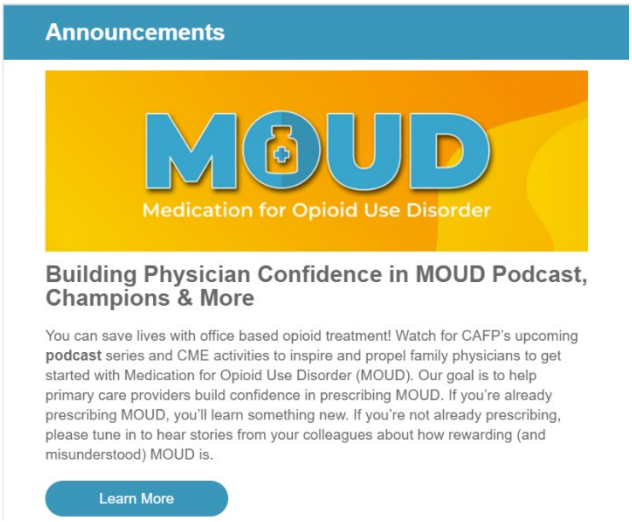
BE A MOUD CHAMPION

This program is sponsored by the California Academy of Family Physicians (CAFP) and supported by the California Department of Health Care Services (DHCS).

In an effort to build Physician confidence in providing MOUD, we developed a MOUD Champions Network. CAFP is partnering with family physicians and key organizations to help primary care providers reach underserved people with Opioid Use Disorder (OUD), paying particular attention to Medication for OUD (MOUD). We assist patient-facing health care providers connect with MOUD Champions through a CAFP-hosted Champions network.

"[My MOUD Champions] were incredible. They both went over educational resources, training materials, and how to bring success to the new SUD program at our FM Residency clinic site. I had a number of questions which they answered, to bring success to our project and practice. They helped me understand legal perspectives regarding SUD management as well. Overall, I found them to be very helpful. I hope to continue the collaboration moving forward."

We reached our goal of recruiting more than 50 Champion family physicians able to counsel peers who are in nascent phases of office-based opioid treatment. Champions are publicized to our membership through our website, enews bulletins and social media, as well as through word of mouth. Several doctors were paired with a MOUD champion over the grant period, with notable success.

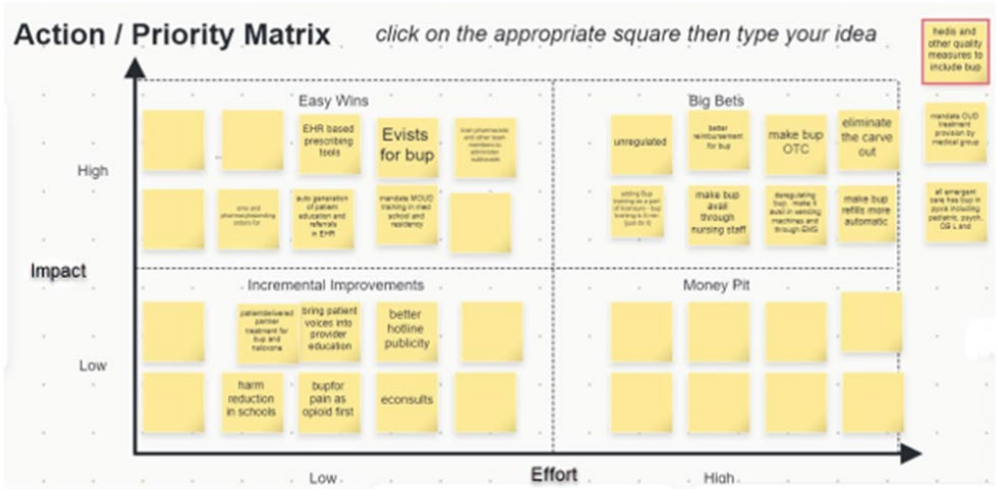


On October 11, 2023, we brought together our Champions for a virtual meeting. Rachel Sussman, MD, a former CRPC grantee, was the moderator for this special gathering. The two goals of this meeting were to:

1. Establish connections with peers in the MAT/MOUD Champion community across California
2. Encourage more physicians to provide life-saving care to their patients with addiction.

Laura Guzman, JD, Executive Director with the National Harm Reduction Coalition presented her organization's efforts to combat stigma and promote harm reduction efforts in California, including a summary of their May 2022 CA Harm reduction Point in Time survey results.

The meeting included small group time for "Blue Sky Thinking" about how to encourage more clinicians to provide life-saving MOUD. Small groups brainstormed, imagining no barriers, then returned to share ideas with the full group.



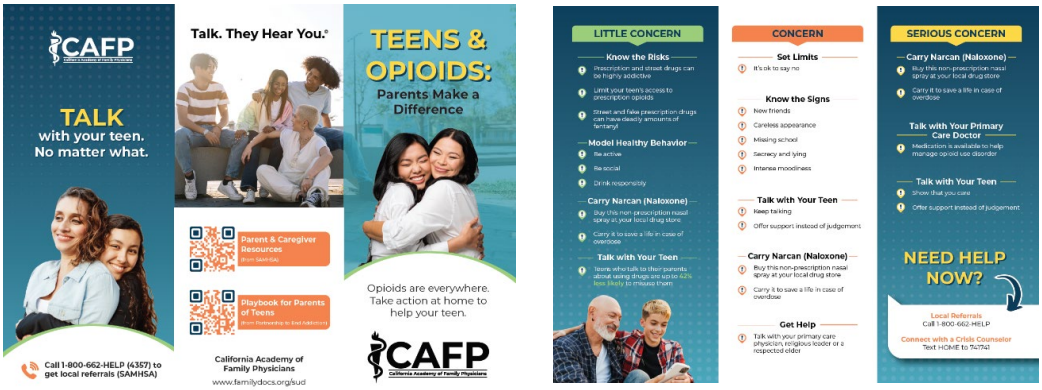
Ideas above & below were generated by small groups during the Blue Sky Thinking exercise. They do not necessarily represent th views of CAFP.

Low Effort, High Impact "Easy Wins": EHR-based prescribing tools E-visits for buprenorphine Train pharmacists and other team members to administer sublocade EMS and pharmacy standing orders for MAT medications Mandate MOUD training in med school and residency	**High Effort, High Impact "Big Bets":** Deregulate buprenorphine Better reimbursement for buprenorphine Make buprenorphine over the counter Eliminate the carve-out Madate OUD treatment provision by medical groups HEDIS and other quality measures to include bup Adding buprenorphine training as part of licensure Make buprenorphine available through nursing staff Buprenorphine in vending machines & through EMS Automate buprenorphine refills Include bup in all emergent care, peds, OB, psych.
Low Effort, Low Impact "Incremental Improvements" Patient delivered partner treatment for buprenorphine and naloxone Bring patient voices into provider education Beter hotline publicity Harm reduction in schools Buprenorphine for pain as opioid first Econsults	

Attendees reported that they connected with new colleagues and that they left the meeting with new ideas about how to encourage more physicians to provide life-saving care to their patients with SUD/OUD. Several of the Champion attendees were tapped for interviews in the new "1 in 5" OUD podcast series. Champions are encouraged to participate in CAFP's ongoing MOUD Discussion Forum in CAFP's new app (https://familydocs.org/app).

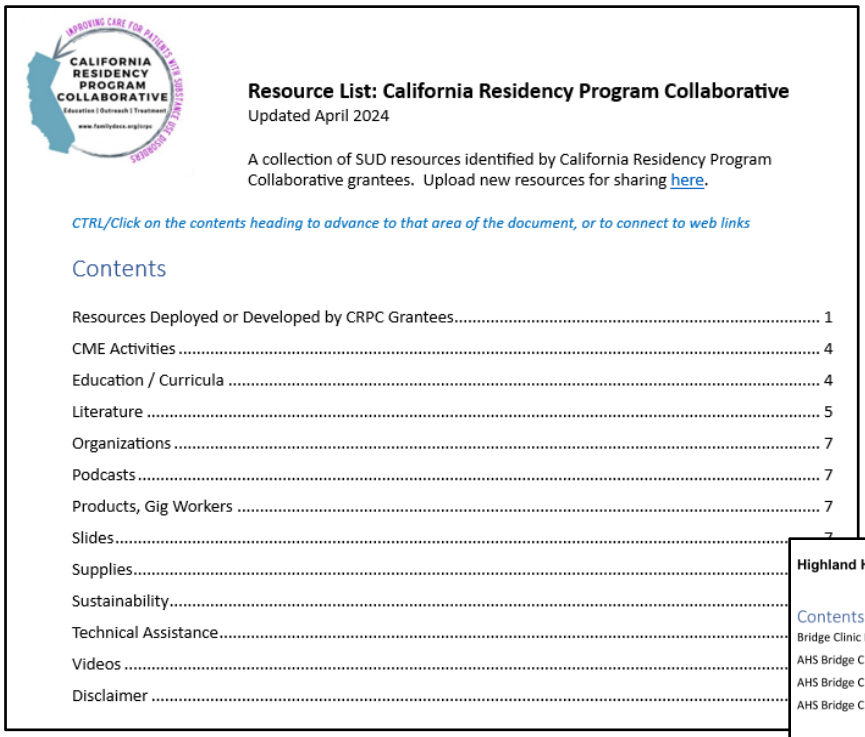
Parents of Youth Awareness Effort

Extensive research and consultation with MOUD Champions with expertise in working with youth and families led to the creation of a parent education brochure. This brochure encourages parents to engage positively with their teenage children regardless of circumstance, while remaining supportive and prepared. Brochures have already been distributed to over 400 family physicians throughout California through chapter meetings and selected PTA organizations, and state and local school board members.

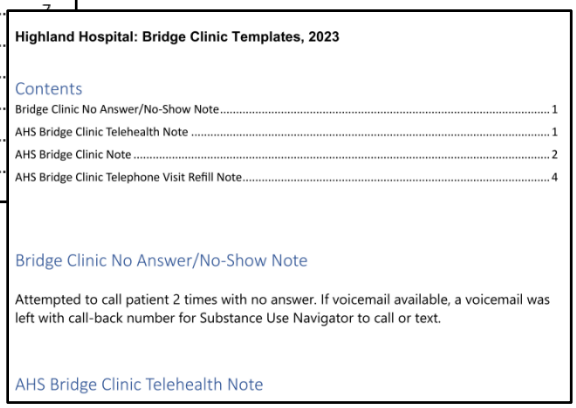


WEBSITE AND ENGAGEMENT

Our CRPC website (https://www.familydocs.org/crpc/) has been a great resource to our grantees and others. It has been accessed 1,965 times during this grant period. We continue to maintain a private site with an access code required that provides grantees with access to their data reporting templates, key initiative dates, the recorded webinars, and contact information of the EAP, all fellow collaborative grantees as well as contact information for our former SOR grantees.

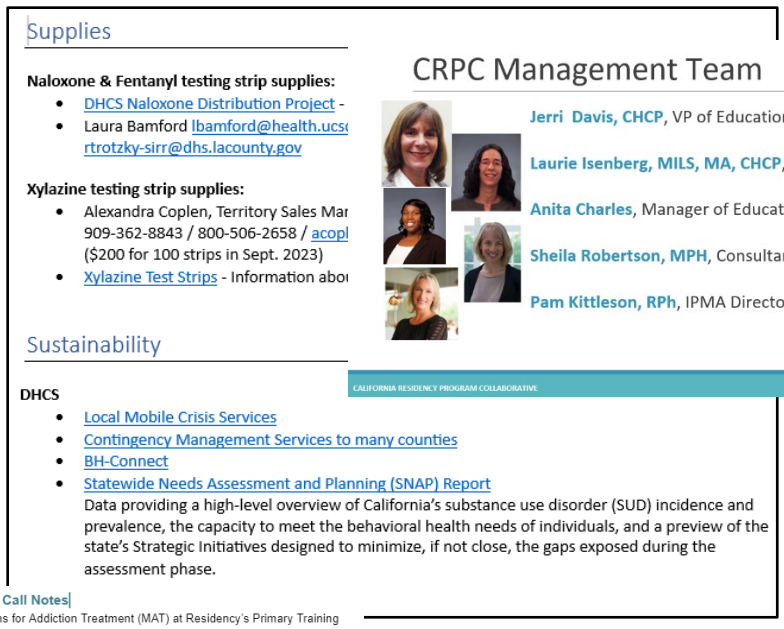


The CRPC private website also gives grantees access to the terrific resources that their colleagues have shared and ones that we've identified throughout the course of this grant. Participants have shared screening tools, workflows, notes templates, order sets, suppliers, patient education, curricula, and more.



CRPC Management Team: Regular Check-ins, Emails and Connection

The CRPC Grant staff management team met throughout the to ensure all grant were



Supplies

Naloxone & Fentanyl testing strip supplies:

- DHCS Naloxone Distribution Project -
- Laura Bamford lbamford@health.ucs
  rtrotzky-sirr@dhs.lacounty.gov

Xylazine testing strip supplies:

- Alexandra Coplen, Territory Sales Mar
  909-362-8843 / 800-506-2658 / acopl
  ($200 for 100 strips in Sept. 2023)
- Xylazine Test Strips - Information abo

Sustainability

DHCS

- Local Mobile Crisis Services
- Contingency Management Services to many counties
- BH-Connect
- Statewide Needs Assessment and Planning (SNAP) Report
  Data providing a high-level overview of California's substance use disorder (SUD) incidence and prevalence, the capacity to meet the behavioral health needs of individuals, and a preview of the state's Strategic Initiatives designed to minimize, if not close, the gaps exposed during the assessment phase.

CRPC Management Team

Jerri Davis, CHCP, VP of Education and Professional Development

Laurie Isenberg, MILS, MA, CHCP, Director of Education and Prof. Devel.

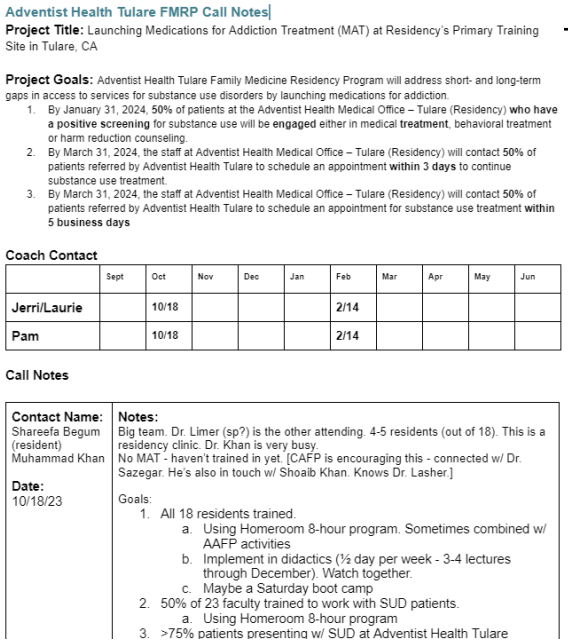
Anita Charles, Manager of Education Programs

Sheila Robertson, MPH, Consultant – Data and Outcomes

Pam Kittleson, RPh, IPMA Director of Quality – QI Coach

CALIFORNIA RESIDENCY PROGRAM COLLABORATIVE — CAFP AND CAFP FOUNDATION

monthly course of the grant components of this coordinated and running smoothly. We kept google planning notes to reflect our progress. CAFP and IPMA arranged check-in calls with all 25 grantees throughout the grant period. To the right is a sample of the notes kept in a google doc so that the CRPC management team members could access them. In addition to the QI specific check-in calls, typically check-ins were meant to get a project status report, ensure that we provided timely assistance to any of the grantees needing it, and to inquire about how we could help ensure their success. We also kept in constant touch with our grantees through email updates and announcements.



Adventist Health Tulare FMRP Call Notes

Project Title: Launching Medications for Addiction Treatment (MAT) at Residency's Primary Training Site in Tulare, CA

Project Goals: Adventist Health Tulare Family Medicine Residency Program will address short- and long-term gaps in access to services for substance use disorders by launching medications for addiction.

1. By January 31, 2024, **50%** of patients at the Adventist Health Medical Office – Tulare (Residency) **who have a positive screening** for substance use will be **engaged** either in medical **treatment**, behavioral treatment or harm reduction counseling.
2. By March 31, 2024, the staff at Adventist Health Medical Office – Tulare (Residency) will contact **50%** of patients referred by Adventist Health Tulare to schedule an appointment **within 3 days** to continue substance use treatment.
3. By March 31, 2024, the staff at Adventist Health Medical Office – Tulare (Residency) will contact **50%** of patients referred by Adventist Health Tulare to schedule an appointment for substance use treatment **within 5 business days**

Coach Contact

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Jerri/Laurie		10/18				2/14				
Pam		10/18				2/14				

Call Notes

Contact Name: Shareefa Begum (resident) Muhammad Khan **Date:** 10/18/23	**Notes:** Big team. Dr. Limer (sp?) is the other attending. 4-5 residents (out of 18). This is a residency clinic. Dr. Khan is very busy. No MAT - haven't trained in yet. [CAFP is encouraging this - connected w/ Dr. Sazegar. He's also in touch w/ Shoaib Khan. Knows Dr. Lasher.] Goals: 1. All 18 residents trained. a. Using Homeroom 8-hour program. Sometimes combined w/ AAFP activities b. Implement in didactics (½ day per week - 3-4 lectures through December). Watch together. c. Maybe a Saturday boot camp 2. 50% of 23 faculty trained to work with SUD patients. a. Using Homeroom 8-hour program 3. >75% patients presenting w/ SUD at Adventist Health Tulare

Conclusion/Photos

As we conclude our 14 months of working together on such a gratifying project, we are humbled by the hard work and dedication of so many individuals and organizations that have gone above and beyond to improve patient care for patients with OUD/SUD now and in the future. As we stated in the opening summary, this experience has truly changed the way that many of these residency programs now

function – with increased systems that streamline everything from x-waiver certification, MAT induction, Narcan distribution, warm handoffs and much more. Many grantees stressed the importance of culture change and credited this change to their program's success.

Following are a few slides showing some of what our grantees have accomplished together throughout the course of their work.

You Focused on the Patient

Conducted a Teenage Advisory Council

Teenage (patient) Advisory Counsil – Kaiser Permanente (Santa Rosa)
Monday, 11/20, 4-5:00p, MOB4, 5
Opioid Use Disorder Grant: Education and Expansion of Services

Dr. David Della Lana (Family Doctor and KP Residency Program Faculty with special interest in substance use issues) asked questions about opioid use among teens. Discussion included "opioids plus" (vaping, drinking, etc.).

Most Relevant Local (Observed) SUD Issues [from teen leader perspectives]:

1. Usage spreads to other friends within a friend group (peer pressure)
2. Also challenging when a friend starts using because, even if you don't also use, you are concerned and don't know how to help
3. Really effected by who your friends are and where you're growing up
4. Parents are not giving the best resources / solutions. Want kids to experiment: more of a "hands-off" – "you need to figure this out yourself" approach
5. Some parents enable/condone ("as long as they do it in my house")
6. Substance use can also be part of a want to fit into certain social groups. Some people pretend to use, some use so they're invited to parties.
7. Rampant on school campuses. Students who don't vape, etc. don't want to use the bathrooms anymore because it's a place people congregate to vape, get high, drink, etc.
8. Schools don't prioritize the prevention of vaping or the education of substance / alcohol abuse. Would like to see schools take it more seriously (patrol the bathrooms, etc.).
9. Most education takes place in middle school or briefly in 9th grade

Seeking Help/Interventions:

1. Challenging because it's so normalized many people don't seek help

Took care to patients in their community

Sought Lived Experience to Inform Improvement

Informational Interview
with a person who has lived experience using drugs

Choose a team leader who will summarize your points at the end of the session

Possible Questions/Talking Points

General

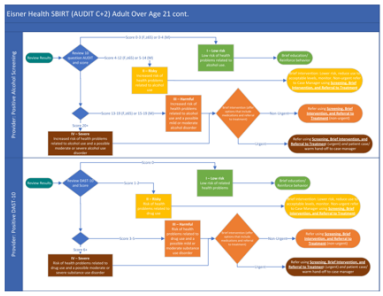
1. What drugs did you use and when did/do you use them? Were they expensive? How did you use them?
2. What did you like about drugs? What didn't you like about drugs?
3. How did drugs positively impact your life? How did they negatively impact your life?
4. Did you meet any nice people while using drugs?
5. Why do you think people use drugs?

CAFP AND CAFP FOUNDATION

You Focused on Teamwork

You Improved Systems and Processes

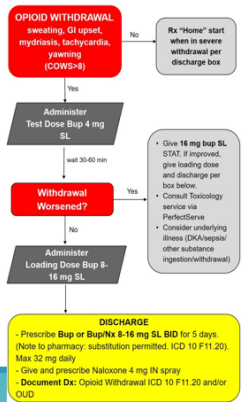
Workflows



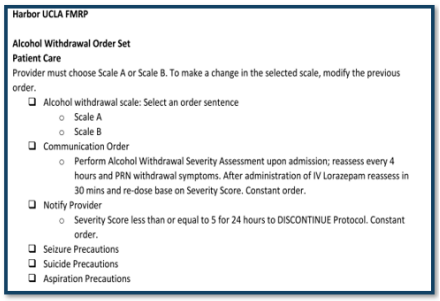
CALIFORNIA RESIDENCY PROGRAM COLLABORATIVE

Protocols

Joe's Buprenorphine (Bup) Quick Start



Order Sets



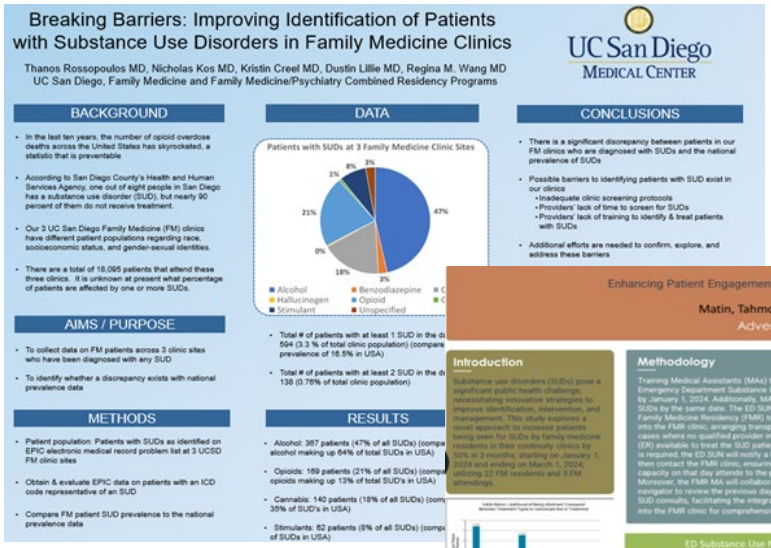
Harbor UCLA FMRP

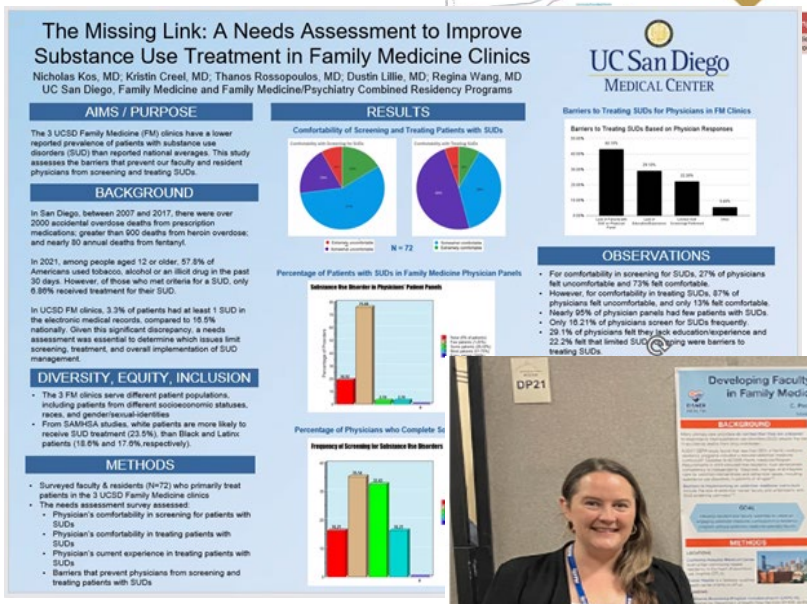
Alcohol Withdrawal Order Set
Patient Care
Provider must choose Scale A or Scale B. To make a change in the selected scale, modify the previous order.

- ❑ Alcohol withdrawal scale: Select an order sentence
  - ○ Scale A
  - ○ Scale B
- ❑ Communication Order
  - ○ Perform Alcohol Withdrawal Severity Assessment upon admission; reassess every 4 hours and PRN withdrawal symptoms. After administration of IV Lorazepam reassess in 30 mins and re-dose base on Severity Score. Constant order.
- ❑ Notify Provider
  - ○ Severity Score less than or equal to 5 for 24 hours to DISCONTINUE Protocol. Constant order.
- ❑ Seizure Precautions
- ❑ Suicide Precautions
- ❑ Aspiration Precautions

CAFP AND CAFP FOUNDATION

One highlight to point out is that many of our residents used their CRPC work to develop and present **posters** at various events. This is an important part of their scholarly work requirements, and we are thrilled they chose to focus their collaborative work in these efforts.





Appendix I includes final reports from each of our 25 California Residency Program Collaborative grantees. All twenty-five residency programs reported their data on a quarterly basis and all twenty five expended their full funding and reconciled their budgets. CAFP-F has also expended all funds and reconciled our overall budget showing a final invoice payment due for Exhibit B, Attachment II deliverables D#38 and D#39, of $22,500.

PHOTOS

Following are selected images from many of our 25 CA Residency Program Grantees.


SJ HEALTH
San Joaquin Health Centers
MOBILE UNIT


SJ HEALTH
San Joaquin Health Centers
(209) 953-6400
www.sjhealth.org


CLINICA SIERRA VISTA
Mobile Clinic


Education Outreach Treatment


Education Outreach Treatment


California Hospital Medical Center
A Dignity Health Member
ADDICTION MEDICINE LECTURE SERIES
The California Hospital Medical Center Family Medicine Residency Program Addiction Medicine Lecture Series provides a lecture series of foundational knowledge in substance use disorders, including screening, evaluation, and treatment.
LEARNING OBJECTIVES
At the completion of each activity, the learner will be able to:
1. implement screening tools for substance use disorder in primary care,
2. accurately diagnose substance use disorders using DSM-5 criteria, and
3. initiate initial intervention/management and/or refer to treatment using appropriate community resources for substance use disorders.
TARGET AUDIENCE
This lecture series is designed for physicians, advance practice providers, residents, students, and other health professionals involved in the management of patient who use substances.
COURSE DIRECTOR
Course Director: C. Peony Khoo, MD
Disclosure: Presenters and all other members of the planning committee have no relevant financial relationships with a commercial interest to disclose
OPIOID USE
DECEMBER 8, 2023
1:00 PM - 2:00 PM
Join via Zoom:
Meeting ID: 836 6062 4371
Password: 564 588 52
Link:
or scan QR code
ACCREDITATION
The California Hospital Medical Center is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.
California Hospital Medical Center designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s). Physicians should claim only the credit commensurate with the extent of their participation in the activity.


OVERDOSE KIT
KIT SOBREDOSIS


St. Joes


AdventistHealth
AdventistHealth


Adventist Health
Physicians Network
Medical Offices